SHEET METAL | AIR | RAIL | TRANSPORTATION

SHEET METAL WORKERS LOCAL NO. 71 HEALTHCARE PLAN

SUMMARY PLAN DESCRIPTION

Effective Date: January 1, 2020

Sheet Metal Workers Local Union No. 71
Healthcare Plan

24 Liberty Ave.
Buffalo, NY 14215
Phone: (716) 835-8836
Fax: (716) 835-8496
www.smartlocal71.com

The Fund is administered by:
THE BOARD OF TRUSTEES

The Trustees of the Plan are:

Union Trustees	Contractor Trustees
Paul Crist 24 Liberty Ave. Buffalo, NY 14215	Robert Beck 2100 Colvin Blvd. Tonawanda, NY 14150
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Jeffrey Meyer 24 Liberty Ave. Buffalo, NY 14215	Richard Wagner 495 Kennedy Rd. Buffalo, NY 14227

Fund Counsel Is:

Mr. Mark Stulmaker
Lipsitz Green Scime Cambria

42 Delaware Avenue #120
Buffalo, New York 14202

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INTRODUCTION

This booklet is the Plan Document for the Sheet Metal Workers Local No. 71 Healthcare Plan and is also intended to operate as your Summary Plan Description. We invite you to carefully review these Plan provisions. This booklet explains the benefits available to you and your family through the Plan. This comprehensive Plan helps to provide financial security for you and your family when you are faced with large health care expenses. We hope this booklet will serve not only as a guide but also as evidence of our concern for the welfare of you and your family.

Covered Services under the Plan will be subject to any Coinsurance, Copayments, maximums and deductible amounts as applicable as shown in the Coverage Summary.

This booklet is not an employment contract or an offer to enter into an employment contract. Plan benefits and rights to Plan benefits will never vest. Retirement does not in any manner confer upon a Covered Family Member any right to continued benefits under this Plan. This Plan is subject to ERISA. For more information on your rights as a participant under this Plan, see the section entitled “Statement of ERISA Rights”.

It is our intention to continue the Plan indefinitely and to make contributions to the Plan. However, we reserve the right to amend the Plan at any time and will notify you within 60 days after the effective date of any Plan amendment that would reduce any benefit. We also reserve the right to terminate the Plan at any time provided that we have given you at least 60 days advance notice of our intention to do so. Should the Plan be terminated for any reason, the assets of the Plan, if any, will continue to be used to provide benefits for Covered Services received before the date of the termination, in the order received, until such time as the assets, if any, are exhausted.

If you have any questions relating to Eligibility, classification or coverage under the Plan, submit them to the Plan Administrator.

Board of Trustees
Sheet Metal Workers Local No. 71 and Industry Welfare Fund

CONTACT INFORMATION

If You Need Information About…	Contact…
Medical Claims Administrator	**Nova Healthcare Administrators**
Locating a Medical Provider Pre-Certification Claim Questions COBRA	Customer Service: (716) 773-2122 or (800) 999-5703 www.novahealthcare.com Claims Address P.O. Box 211428 Eagan, MN 16644 Payor ID 16644 Group: 918
24 Hour Medical Help Line	(844) 668-2365
Dental Claims Administrator	**Nova Healthcare Administrators**
Locating a Dental Provider Claim Questions COBRA	Customer Service: (716) 773-2122 or (800) 999-5703 www.novahealthcare.com Claims Address P.O. Box 211428 Eagan, MN 16644 Payor ID 16644 Group: 918
Pharmacy Claims Administrator	**Pharmacy Benefit Dimensions**
Prescription Questions	Customer Service: (716) 635-7880 or (888) 878-9172 www.pbdrx.com
Claims	Claims Address Attn: Pharmacy Department 511 Farber Lakes Drive Buffalo, NY 14221 RxBIN: 004626 RxGroup: 918A
Mail Order Prescription Drugs	**Wegmans Mail Order:** www.wegmans.com/pharmacy **ProAct Mail Order:** www.proactpharmacyservicespbd.com 1-800-934-4797 or 1-888-205-8573 1-888-425-3301 or 1-877-635-9545
Specialty Medications (Reliance Rx)	(716) 635-7880 or tollfree at 1-888-878-9172
Teladoc	
Telemedicine	Phone: 1-800-Teladoc or (800) 835-2362 Website: www.Teladoc.com/Nova Mobile App: Teledoc Member
Fund Office	**Sheet Metal Workers Local Union No. 71 Healthcare Plan**
Eligibility Life Insurance Benefit Disability Income Benefit	Phone: (716) 835-8836 Fax: (716) 835-8496 Website: www.smartlocal71.com Email: info@smartlocal.com 24 Liberty Ave. Buffalo, NY 14215

MEDICAL COVERAGE SUMMARY EFFECTIVE JANUARY 1, 2020			
Medical Benefit Description	**Network Providers**	**Out-of-Network**	**Notes, Limitations**
Deductible Per Calendar Year	**None**	**Not Covered**	
Out-of-Pocket Maximum; Includes medical and pharmacy.	**$7,350 Individual / $14,700 Family**	**Not Covered**	**The Out-of-Pocket Maximum is the most you could pay in a year for covered services. If you have other family members in this Plan they have to meet their own Out-of-Pocket Maximum until the overall family Out-of-Pocket Maximum has been met. Not included in the Out-of-Pocket Maximum: premiums, balance-billed charges, penalty amounts and non-covered services.**
Dependent Age Limitations	**Up to age 26**		
Pre-Existing Conditions Limitations	**Pre-existing condition limitations do not apply.**		
Pre-Certification Requirements	**See coverage summary on the following pages for services that require pre-certification.** **Contact Nova toll-free at (800) 999-5703.**		
Pre-Certification Penalty	**$250.00 penalty per claim if Pre-Certification is not obtained on required services.**		
Timely Filing of Claims	**All claims must be filed within one year from the date the claim is incurred or the claim will be denied.**		
Network Providers Independent Health First Health (Out of Area Network)	**Due to changes that may occur in the participation status of the Provider, it is the responsibility of the Employee to verify that the Provider is still a Participating member.** **A list of Network Providers is available from NOVA Healthcare Administrators (www.novahealthcare.com) or the phone number on your ID Card.**		
Independent Health 24-hour Nurse Hotline	**(844) 668-2365**		

Medical Benefit Description	Network Providers	Out-of-Network	Notes, Limitations
Acupuncture	Not Covered	Not Covered	
Alcohol/Substance Abuse			
Inpatient Rehabilitation	$500 Copay	Not Covered	**Pre-Certification is Required**
Inpatient Physician	$0 Copay	Not Covered	
Outpatient/Office	$20 Copay	Not Covered	
Allergy			
Office Visit	$20 Copay	Not Covered	
Treatment (Injections)	$20 Copay	Not Covered	
Serum	$0 Copay	Not Covered	
Laboratory & Scratch Testing	$0 Copay	Not Covered	
Ambulance	$150 Copay	$150 Copay	
Anesthesia			
Inpatient	$0 Copay	Not Covered	
Outpatient	$0 Copay	Not Covered	
Office	$0 Copay	Not Covered	
Assistant Surgeon	$0 Copay	Not Covered	
Biofeedback	Not Covered	Not Covered	
Blood and Blood Products	$0 Copay	Not Covered	
Cardiac Rehabilitation	$20 Copay	Not Covered	
Chemotherapy	$20 Copay	Not Covered	**Pre-Certification Required**
Chiropractic Care	$20 Copay	Not Covered	**Limited to 25 visits per calendar year** **Maintenance therapy not Covered**
Contraceptives (Not administered in the office)	Refer to Prescription Drug Benefit	Not Covered	
Cosmetic Surgery	Not Covered	Not Covered	
Custodial Care	Not Covered	Not Covered	
Dental Care			
Accidental Injury to Teeth	Based on where services occur.	Not Covered	**Pre-Certification Required.** Treatment must be rendered within 12 months of the date that the Injury occurred
Diabetic Equipment & Supplies			
Diabetic Equipment (e.g. Blood Glucose Monitor, Insulin Pump)	20% Coinsurance	Not Covered	**Pre-Certification Required**
Supplies for durable medical insulin injecting equipment	20% Coinsurance	Not Covered	**Pre-Certification Required if DME is over $250.00**
Diabetic Medication and Diabetic Supplies (lancets, lancing devices, alcohol swabs & test strips	Covered under Pharmacy Benefit	Not Covered	
Diagnostic Testing (EKG, Stress Tests)	$20 Copay	Not Covered	
Dialysis or Hemodialysis	$20 Copay	Not Covered	
Durable Medical Equipment (DME)			**Pre-Certification Required if DME is over $250.00**

Medical Benefit Description	Network Providers	Out-of-Network	Notes, Limitations
Breast Pump Supplies	50% Coinsurance	Not Covered	
Compression Stockings	50% Coinsurance	Not Covered	**Five per calendar year**
Durable Medical Equipment	50% Coinsurance	Not Covered	
Disposable Medical Supplies	50% Coinsurance	Not Covered	**Covers only Medically Necessary supplies required for the proper functioning of Durable Medical Equipment**
Mastectomy Bra	50% Coinsurance	Not Covered	**Six per calendar year**
Prosthetics (External)	50% Coinsurance	Not Covered	
Prosthetics (Internal)	$0 Copay	Not Covered	
Foot Orthotics	50% Coinsurance	Not Covered	
Orthotics (Braces)	50% Coinsurance	Not Covered	
Ostomy Supplies	50% Coinsurance	Not Covered	
Oxygen	50% Coinsurance	Not Covered	
Wig	50% Coinsurance	Not Covered	**Two per calendar year**
Emergency Room	$250 Copay	$250 Copay	**Includes ER Physician**
Enteral Formula and Supplies	Not Covered	Not Covered	
Gene Therapy	Not Covered	Not Covered	
Hearing Exam	$20 Copay	Not Covered	**Limited to one per calendar year**
Hearing Aids	Not Covered	Not Covered	
Home Health Care	$20 Copay	Not Covered	**Pre-Certification Required.** Maximum 45 days per calendar year
Hospice Care			**Pre-Certification Required** Limited to 210 days Lifetime
Bereavement Counseling	$0 Copay	Not Covered	
Inpatient	$0 Copay	Not Covered	
Home	$0 Copay	Not Covered	
Hospital Inpatient			
Facility	$500 Copay	Not Covered	**Pre-Certification Required**
Physician/Provider Hospital Visit	$0 Copay	Not Covered	
Hospital Observation Room	$250 Copay	Not Covered	
Infusion / Injection Medication (Home or Office)	10% Coinsurance / $100 maximum per visit	Not Covered	**Pre-Certification Required Office visit copay may apply**
Laboratory	$20 Copay	Not Covered	
Massage Therapy	Not Covered	Not Covered	
Maternity Care			
Prenatal and Postnatal Visits	$0 Copay	Not Covered	**$20 Copay for first visit only then Covered at 100%**
Delivery - Facility	$500 Copay	Not Covered	**Post Certification is Required if stay exceeds 48 hours for vaginal delivery or 96 hours for Cesarean**

Medical Benefit Description	Network Providers	Out-of-Network	Notes, Limitations
Newborn - Facility	$500 Copay	Not Covered	**Pre-Certification is recommended, but not required when the newborn will be a Covered Family Member but the mother will not be Covered. Post-Certification is required when any newborn's Hospital confinement exceeds 48 hours after birth following a normal delivery or 96 hours after birth following a cesarean section.**
Delivery – Physician/Provider	$0 Copay	Not Covered	
Mental Health			
Inpatient Facility	$500 Copay	Not Covered	**Pre-Certification Required**
Inpatient Physician/Provider	$0 Copay	Not Covered	**Pre-Certification Required**
Outpatient	$20 Copay	Not Covered	**Pre-Certification Required**
Office	$20 Copay	Not Covered	
Modified Food Products	Not Covered	Not Covered	
Occupational Therapy	$20 Copay	Not Covered	**Pre-Certification Required after 10 visits with a** 30 visits per calendar year maximum.
Outpatient Surgical Procedures			
Facility	$150 Copay	Not Covered	**Pre-Certification Required**
Clinic	$20 Copay	Not Covered	
Office	$20 Copay	Not Covered	
Physical Rehabilitation Facility	$250 Copay	Not Covered	**Pre-Certification Required**
Physical Therapy	$20 Copay	Not Covered	**Pre-Certification Required after 10 visits with a** 30 visits per calendar year maximum.
Podiatry	$20 Copay	Not Covered	
Pre-Admission Testing	$20 Copay	Not Covered	
Physician/Provider Office/Home Visit	$20 Copay	Not Covered	
Preventive Services Abdominal Aortic Aneurysm Screening Annual Routine Screening Bacteria Screening, Urine Bone Density Breastfeeding Pump Rental* Breastfeeding Support and Counseling Cardiovascular Screening Chlamydia Screening Contraceptive Counseling Contraceptives (administered in Providers office) Counseling for Sexually Transmitted Infections and HIV Diabetes Screening Diabetic Teaching Domestic Violence Screening Gestational Diabetes Screening General Health Panel with Basic Metabolic Panel Gonorrhea Screening Hemoglobin and Hematocrit HIV screening HPV Screening Immunizations Lead Screen (children 0-18 and pregnant females only) Mammogram Nutritional Counseling Occult Blood P.S.A Testing Pap Smear Preventive Medicine Services Rh Screen Rubella Screen Screening Colonoscopy, Flexible Sigmoid Syphilis Infection Screening Well Child Visit Well Woman Visit	$0 Copay	Not Covered	Preventive/Well Care is Covered as defined in the Patient Protection and Affordable Care Act, as amended Including but not limited to the services listed. This list will include all services that have a rating of A or B from the United States Preventive Services Task Force and their corresponding limitations. *Only RENTAL of Breast Pump Covered Breast Pump supplies are Covered under the DME benefit.

Medical Benefit Description	Network Providers	Out-of-Network	Notes, Limitations
Private Duty Nursing	Not Covered	Not Covered	
Pulmonary Rehabilitation	$20 Copay	Not Covered	**Pre-Certification Required**
Radiation Therapy	$20 Copay	Not Covered	**Pre-Certification Required**
Radiology			
X-Ray	$20 Copay	Not Covered	
Advance Radiology (ie. MRI / MRA / PET / CT)	$75 Copay	Not Covered	**Pre-Certification is Required**
Skilled Nursing Facility (Sub-acute)	$250 Copay	Not Covered	**Pre-Certification Required.** 45 Day Limit per Calendar Year
Sleep Studies	$20 Copay	Not Covered	
Speech Therapy	$20 Copay	Not Covered	**Pre-Certification Required after 10 visits with a** 30 visits per calendar year maximum.
Sterilization			
For Females	$0 Copay	Not Covered	**Pre-Certification Required**
For Males	Covered Under Surgery Benefit	Not Covered	**Pre-Certification Required excluding office based settings**
Surgery			
Physician/Provider In-Patient	$0 Copay	Not Covered	
Physician/Provider Outpatient	$0 Copay	Not Covered	
Telemedicine (Teladoc)	$20 Copay	Not Covered	**(800) 835-2362** **See Contact Information page for website**
Urgent Care	$40 Copay	Not Covered	
Vision			
Medical	$20 Copay	Not Covered	
Post Cataract Glasses	Covered under DME Benefit	Not Covered	**Pre-Certification Required**
Eye Exam	$20 Copay	Not Covered	**Limit one per calendar year**

PRESCRIPTION COVERAGE SUMMARY **EFFECTIVE JANUARY 1, 2020**			
Prescription Benefit Description	**Benefit**		**Notes, Limitations**
Retail Drugs	Tier One - Prefered Generics & Brands Tier Two - Prefered Brands Tier Three - Non-Prefered Brands Tier Four - Preferred Specialty Tier Five - Non-Preferred Specialty	$5 Copay $20 Copay $45 Copay $100 Copay $150 Copay	30-day supply Based on PBD 5 Tier Formulary
	Tier One - Prefered Generics & Brands Tier Two - Prefered Brands Tier Three - Non-Prefered Brands Tier Four - Preferred Specialty Tier Five - Non-Preferred Specialty	$15 Copay $60 Copay $135 Copay N/A N/A	90-day supply (Maintenance Drugs) Based on PBD 5 Tier Formulary
Mail Order Maintenance Drugs	Tier One - Prefered Generics & Brands Tier Two - Prefered Brands Tier Three - Non-Prefered Brands Tier Four - Preferred Specialty Tier Five - Non-Preferred Specialty	$12.50 Copay $50 Copay $112.50 Copay N/A N/A	90-day supply (Maintenance Drugs) Based on PBD 5 Tier Formulary

DENTAL COVERAGE SUMMARY **EFFECTIVE JANUARY 1, 2020**		
Dental Benefit Description	**Network Providers**	**Out-Of-Network**
Deductible Per Calendar Year	**None**	**None**
Annual Maximum	**$1,000.00 / Per Covered Family Member**	
Dependent Age Limitations	**Up to age 19**	
Timely Filing of Claims	**All claims must be filed within one year from the date the claim is incurred or the claim will be denied.**	
Network Providers **Nova Dentalcare Network**	**A list of Preferred Providers is available from NOVA Healthcare Administrators (www.novahealthcare.com) or the phone number on your ID Card.**	

Dental Benefit Description	**Network Providers** The Plan pays based on the fee schedule Allowed Amount.	**Out-of-Network** The Plan pays based on the fee schedule Allowed Amount.	**Notes, Limitations**
Preventive Services			
Initial / Periodic Exams	100%	100%	
Bitewing X-Rays	100%	100%	
Cleanings	100%	100%	
Full Mouth X-Rays	100%	100%	Limited to every 3 years

Dental Benefit Description	**Network Providers** The Plan pays based on the fee schedule Allowed Amount.	**Out-of-Network** The Plan pays based on the fee schedule Allowed Amount.	Notes, Limitations
Fluoride	100%	100%	1 per Calendar Year, Covered to age 18
Oral Exams	100%	100%	
Sealants	100%	100%	1 per tooth per 36 months; Up to age 18
Basic Services			
Anesthesia	65%	65%	With medical necessity
Emergency Dental Treatment	65%	65%	
Extractions	65%	65%	
Occlusal Guard	65%	65%	Covered for Bruxism/Habit Breaking only
Oral Surgery	65%	65%	
Periodontics	65%	65%	
Fillings (Amalgam and Composite)	65%	65%	Excludes gold fillings
Root Canal	65%	65%	
Major Services			
Crowns	40%	40%	Five year rule applies; replacement Covered five years after installation only
Dentures	40%	40%	Includes all adjustments made during a six month period following installation; Five year rule applies; replacement Covered five years after installation only
Fixed Bridges	40%	40%	Includes all adjustments made during a six month period following installation; Five year rule applies; replacement Covered five years after installation only
Major Services			
Dental Implants	40%	40%	
Inlays / Onlays	40%	40%	
Tissue Conditioning	40%	40%	

Note: This Coverage Summary is intended to be a general description of benefits only. Some limitations, conditions, or exclusions may apply. The benefits listed above are subject to change at any time. If there is a discrepancy between this overview and the Plan Document, the Plan Document will prevail. Services must be Medically Necessary treatment of Sickness or Injury, unless otherwise stated. The fact that a physician may prescribe, order, recommend or approve a service or supply does not, of itself, make it Medically Necessary even though it is not specifically listed as an exclusion. All of the facts and circumstances surrounding the claim must be considered.

DEFINITIONS

The terms defined in this section have been capitalized throughout this document.

Active Service means that you are currently employed by an Employer under a Collective Bargaining Agreement (CBA) or participation agreement requiring your Employer to remit contributions to the Sheet Metal Workers Local Union No. 71 Healthcare Plan for your classification. The term Active Service includes periods during which you are ready, willing and able to perform duties required under the CBA, but not currently employed by an Employer under the CBA due to an involuntary layoff or termination or approved leave under the Family and Medical Leave Act (FMLA) or New York Paid Family Leave Law (NYPFLL).

Adoption Date means the January 1, 2020 restated effective date.

Adverse Benefit Determination or **Adverse Determination** means any whole or partial denial of benefits, reduction of benefits, termination of benefits, or failure to provide or make benefit payment under the Plan. An Adverse Benefit Determination includes, but is not limited to, amounts applied to the deductible, a Copayment, or a Coinsurance percentage payable by a Covered Family Member, or an amount applied as a penalty when Plan procedures are not followed. Adverse Determination also applies to a Covered Family Member's eligibility, the application of Pre-Certification, the determination of an Experimental or Investigational treatment, and the determination of Medical Necessity.

Allowable Expense means the maximum amount the Plan will pay to a Provider for the services or supplies Covered under this Plan before any applicable deductible, Copayment and Coinsurance amounts are subtracted. The Plan will only pay Out-of-Network Providers for Emergency services, certain services not within the control of the Covered Family Member or approved services when there is no Network Provider within a 50-mile radius of the member's residential zip code. The Covered Family Member's deductible, Copayment and Coinsurance amounts are based on the Allowable Expense, except as mentioned below. The Allowable Expense is determined as follows:

(1) The Allowable medical Expense for a Covered Service received from a Network Facility is the amount set by State or Federal law. In the absence of State or Federal law the Allowable Expense will be the amount that has been negotiated with the Facility.

(2) The Allowable medical Expense for a Covered Service performed by a Network Provider will be the lower of:
   (A) The Network Provider Reimbursement Schedule; or
   (B) The Provider's billed charges

(3) The Allowable medical Expense for a Covered Emergency Service, certain services not within the control of the Covered Family Member or approved services when there is no Network Provider within a 50-mile radius of the member's residential zip code performed by an Out-of-Network Provider will not exceed the higher of:
   (A) The median Network negotiated rate;
   (B) The Medicare rate; or
   (C) The 85th percentile of the Reasonable and Customary rate

Authorized Representative means any individual designated by the Covered Family Member to assist or act on behalf of the Covered Family Member with respect to a Pre-Service Claim, a Post-Service Claim, a Concurrent Claim, or an Urgent Care Claim. A Provider with knowledge of the Covered Family Member's medical condition is an Authorized Representative. An Authorized Representative may request and receive any documentation that the Plan used to make a determination, including medical records.

Balance Billing means when an Out-of-Network Provider bills you for the difference between the Out-of-Network Provider's charge and the Allowed Amount. A Network Provider may not balance bill you for the covered services.

Behavioral Health Care Facility means a facility that specializes in the treatment of Substance Abuse or Mental Illness which is certified in accordance with the applicable laws of the appropriate legally authorized agency, which is accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), Medicare, or by the state in which it operates. For Covered Family Members who are entitled to Medicare, a Behavioral Health Care Facility must be a provider of services under Medicare.

Benefit Determination or **Determination of Benefits** means the calculation made by the Claim Administrator of any amount payable by the Plan. The Determination of Benefits payable will be made whenever proof of claim is submitted.

Brand Name Drug means a drug that is protected by the trademark registration of the pharmaceutical Company that produces it.

Business Associate means a person or organization, other than one which is a member of the Covered Entity's workforce, that has a direct contractual relationship with the Covered Entity and which receives, uses, discloses, or maintains Protected Health Information for the Covered Entity.

Child means your biological Child, stepchild, legally adopted Child, or Child for whom you are the legal guardian until they turn age 26; age 19 with respect to dental coverage.

A legally adopted Child must have been placed for adoption (whether or not the adoption is final) before the Child's 18th birthday in order to be Eligible under this Plan. Child also means any other individual for whom you are obligated to provide coverage under the terms of any Qualified Medical Child Support Order.

Coverage for any Child who is mentally or physically handicapped, mentally ill, or developmentally disabled, as determined by the Social Security Administration, and incapable of self-sustaining employment can be continued after they reach the limiting age of the Plan if their disability began prior to such age. The disabled Child must be Dependent on you for financial support, as defined by the Internal Revenue Code and the Covered Employee must declare the Child as an income tax deduction. The Employee must provide proof that the Child is incapable of self-sustaining employment within 31 days of the Child reaching the limiting age of the Plan. The disabled Child must meet the above support requirements and submit proof of disability to the Claim Administrator upon request.

A newly hired Employee may also add a disabled Child as a Dependent under the Plan provided the Child is incapable of earning his own living and the disability began prior to reaching the limiting age of the Plan. The disabled Child must remain Dependent upon you for financial support, as defined by the Internal Revenue Code and the Covered Employee must declare the Child as an income tax deduction.

The Plan requires documentation proving financial dependency, including tax records and proof of continuous coverage under any previous Plan(s). The Plan also requires subsequent proof of medical disability and financial dependency once each year. The Plan reserves the right to have such Child examined by a physician of the Plan's choice, at the Plan's expense, to determine such incapacity.

Claim Administrator means the Medical, Dental and Pharmacy Administrators as listed in the Contact Information section at the beginning of this document.

Claim Determination Period means Plan benefits will be determined on a Calendar Year basis.

COBRA Beneficiary means a Covered Family Member who is entitled to and elects to continue health coverage under this Plan in accordance with Section 4980B of the Code. The term will also include a Child who is born or placed for adoption, and any other Eligible Dependent acquired while the Employee is a COBRA Beneficiary.

Code means the Internal Revenue Code of 1986, as presently enacted and as it may be amended from time to time, together with its related rules and regulations. References to any Section of the Code shall include any successor provision.

Coinsurance means the percentage of an Allowable Expense shared by the Covered Family Member and the Plan that must be paid to the Provider.

Collective Bargaining Agreement means any agreement in force and effect between the Union and an Employer, which agreement provides for the payment of periodic contributions to the Fund for health benefits.

Concurrent Claim means a request for benefits arising out of a termination of benefits, request for extension of care or reduction of previously granted benefits being provided over a period of time, or a request to extend a course of treatment.

Convalescent/Skilled Nursing Facility means only an institution (or a distinct part thereof) that meets all the following requirements:

(1) It meets any licensing or certification standards, and
(2) It provides inpatient skilled nursing and physical restoration services for patients convalescing from a Sickness or Injury, and
(3) It is under the full-time supervision of a physician or registered professional nurse who is regularly on the premises at least 40 hours per week, and
(4) It provides skilled nursing services on a 24-hour basis under the direction of a full-time registered professional nurse, with licensed nursing personnel on duty at all times, and

(5) It maintains a complete medical record on each patient, and
(6) It has a utilization review Plan in effect for all of its patients, and
(7) It must have a written agreement or arrangement with a physician to provide Emergency care, and
(8) If not an integral part of a Hospital, it must have a written agreement with one or more Hospitals to provide for the transfer of patients and medical information between the Hospital and the Convalescent/Skilled Nursing Facility, and
(9) With respect to Covered Family Members who are entitled to Medicare, it is an approved provider of services under Medicare, and
(10) It is accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO).

The term Convalescent/Skilled Nursing Facility will not include any institution which is, other than incidentally, a place for the aged, the blind, the deaf, the mentally ill or handicapped, a place for rest, Custodial Care or educational care, drug addicts or alcoholics.

CoPayment or **Copay** means a fixed dollar amount paid to a Provider by a Covered Family Member.

Covered means that a Family Member who is Eligible to participate in the Plan has made written election to do so, and the Plan Administrator has approved participation.

Covered Entity means a health Plan, a health care clearinghouse, or a Provider who transmits health information in an electronic form in connection with a Standard Transaction.

Covered Services means those services, care, treatment, or supplies for which the Plan will make payment. A Covered Service must include routine or Medically Necessary health care for which a diagnosis is identified in the International Classification of Diseases, 10th Version (ICD-10). Covered Services should be identified in the Current Procedural Terminology (CPT) developed by the American Medical Association, by the Common Procedure Coding System (HCPCS) developed by the Health Care Financing Administration, the Hospital Revenue Code applications, or the Current Dental Terminology (CDT) developed by the American Dental Association.

Custodial Care means any service or supply, including room and board, which:

(1) Is furnished mainly to help a person in the activities of daily living, and
(2) Can be furnished by someone with no professional health care training or skills.

Room and board and skilled nursing services, when provided to a Covered Family Member in a Hospital or other institution, shall not be Custodial Care when such services must be combined with other Medically Necessary services and supplies to establish a program of medical treatment which can reasonably be expected to contribute substantially to the improvement of the Covered Family Member's medical condition. Such improvement shall include the restoration of normal or near normal function and/or the general betterment of the Covered Family Member.

Dependent means your Child or legal spouse from whom you are not legally separated, legally divorced, or a legal spouse of an Employee whose marriage has not been legally annulled. A common-law spouse is not recognized as your legal spouse under the Plan, even if it is recognized in the State or municipality of residence, unless you can provide formal evidence of the common-law marriage consistent with applicable state law recognizing the relationship (such as a court ruling or a state-issued declaration recognizing the marriage)..

Disability For purposes of this Plan, you will be deemed disabled if your physician certifies that you are totally disabled to perform your regular occupation and you submit proof of entitlement to Workers Compensation, NYS Disability or Social Security disability.

Durable Medical Equipment means medical equipment that satisfies all the following requirements:

(1) It is generally not useful in the absence of an Injury or a Sickness, and
(2) It is appropriate for use in the home, and
(3) It can withstand repeated use, and
(4) It is Medically Necessary, and
(5) It is not useful or convenient to other household members, and
(6) It is not a convenience item or an aid to daily living.

Eligible means that an individual has met the definition of Family Member and the eligibility requirements of this Plan.

Emergency means a sudden onset of symptoms that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably determine that the absence of immediate medical attention would result in serious physical impairment or death. It also means a situation in which a Covered Family Member appears to have a mental or emotional disorder for which immediate observation, care and treatment is necessary to avoid serious harm to the Covered Family Member or others. Emergency treatment must be rendered within 72 hours of an Injury or within 12 hours of onset of a sudden and serious Illness.

Employee means any person employed by an Employer or Eligible to work for an Employer under a Collective Bargaining Agreement. The term Employee shall also include, any person who is covered under the Disability Coverage benefit and with the consent of the Trustees, persons who are employed by the Sheet Metal Workers Local No. 71 Pension Fund, Sheet Metal Workers Local No. 71 Industry Welfare Fund, Sheet Metal Workers Local No. 71 Annuity Plan and the Union if their Employer has become an Employer under the Plan by making required contributions to the Fund as called for by the Collective Bargaining Agreement.

Employer or **Company** means any Employer who is bound by the terms of the Collective Bargaining Agreement with the Union to Contribute to the Fund. The term Employer will also include the Fund, Pension Fund, Annuity Plan and the Union, provided that each entity makes contributions for its Employees at the same rate as other Employers under the Collective Bargaining Agreement.

Enrollment Date means, for the purposes of complying with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Covered Family Member's Participation Effective Date or, if there is a waiting period for coverage, the first day of such waiting period (the date employment begins). An Enrollment Date for a Family Member who late enrolls under the Plan or who is Eligible for a Special Enrollment Period shall be the Participation Effective Date.

ERISA means the Employee Retirement Income Security Act of 1974, as presently enacted and as it may be amended from time to time, together with its related rules and regulations. References to any Section of ERISA shall include any successor provision.

Essential Health Benefits means benefits as defined by the Secretary of Health and Human Services. Such benefits will include at least the following general categories of benefits:

(1) Ambulatory patient services;
(2) Emergency services;
(3) Hospitalization;
(4) Maternity and newborn care;
(5) Mental health and substance use disorder services, including behavioral health treatment;
(6) Prescription drugs;
(7) Rehabilitative and habilitative services and devices;
(8) Laboratory services;
(9) Preventive and wellness services and chronic disease management; and
(10) Pediatric services, including oral and vision care.

Experimental or **Investigative** means services, supplies, care and treatment that do not constitute accepted medical practice. When determining whether or not a procedure is Experimental or Investigative, the Plan will take into consideration appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.
The Plan must make an independent evaluation of the Experimental/non-Experimental standings of specific technologies. It will be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The Plan will be guided by the following principles:

(1) The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished, except where the laws of the state mandate coverage for any drug not approved by the FDA but recognized as appropriate treatment for a particular type of cancer by an established reference such as the AMA Drug Evaluations, or
(2) The drug, device, medical treatment or procedure, or the patient informed consent document was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval, or
(3) Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, Experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis, or

(4) Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy compared with a standard means of treatment or diagnosis.

Family Member means an Employee, Spouse, Dependent, or a COBRA Beneficiary.

Final Adverse Benefit Determination means a final Adverse Determination involving a Covered benefit that has been upheld by the Plan, or its designee utilization review organization, at the completion of the Plan's internal grievance process procedures as set forth in Health Carrier Grievance Procedure Model Act.

Freestanding Surgical Facility means an institution primarily performing outpatient surgery that meets all the following requirements:

(1) It has a medical staff of physicians, nurses and licensed anesthesiologists, and
(2) It maintains at least two operating rooms and one recovery room, and
(3) It maintains diagnostic laboratory and x-ray facilities, and
(4) It has equipment for Emergency care, and
(5) It has a blood supply, and
(6) It maintains medical records, and
(7) It has agreements with Hospitals for immediate acceptance of patients who need Hospital confinement on an inpatient basis, and
(8) It is licensed in accordance with the laws of the appropriate legally authorized agency, and
(9) It is a provider of services under Medicare with respect to Covered Family Members who are entitled to Medicare, and
(10) It is accredited by the Accreditation Association for Ambulatory Care (AAAC), or the Joint Commission on Accreditation of Health Care Organizations (JCAHO).

Fund or **Welfare Trust Fund** means all contributions made to the Trustees pursuant to and in accordance with the terms of the Collective Bargaining Agreement, together with all income, increments, earnings and profits received by the Trustees, less any expenses paid therefrom.

Gene Therapy means therapy that involves replacing a gene that causes a medical problem with one that does not, adding genes to help the body fight or treat disease, or turning off genes that cause medical problems.

Generic Drug means the chemical name for a drug. By law, a Generic Drug must meet the same standard for safety, surety, strength and effectiveness as a Brand Name Drug.

Health Care Facility means any licensed facility, other than acute care Hospitals and those facilities providing services to ventilator dependent patients, which provides inpatient services such as skilled nursing care and rehabilitative services.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Care Agency means a hospital, agency or organization that meets all the following requirements:

(1) It primarily provides skilled nursing services or other therapeutic services and is duly licensed by the appropriate licensing authority, and
(2) It has policies established by a professional group associated with the agency or organization consisting of at least one physician and at least one registered professional nurse to govern the services provided (it must provide for full-time supervision of such services by a physician or by a registered professional nurse), and
(3) It maintains a complete medical record on each patient, and
(4) It has a full-time administrator, and
(5) It is a provider of services under Medicare with respect to Covered Family Members who are entitled to Medicare, and
(6) It does not primarily provide Custodial Care, care and treatment of the mentally ill, or care of drug addicts, alcoholics, and the handicapped.

Hospice Care Agency means a hospital, agency or organization that meets all the following requirements:

(1) It has hospice care available 24-hours-a-day, and

(2) It meets any licensing or certification standards of the jurisdiction where it is located, and
(3) It provides skilled nursing services, medical social services, psychological and dietary counseling, and bereavement counseling for the immediate family, and
(4) It provides or arranges for other services including; (a) services of a physician, (b) physical or occupational therapy, (c) part-time Home Health Aide services which mainly consist of caring for terminally ill individuals, and (d) inpatient care in a facility when needed for pain control, and
(5) It has personnel including at least one physician, one registered professional nurse, one licensed or certified social worker and one pastoral or other counselor, and
(6) It establishes policies governing the provision of hospice care, and
(7) It assesses the patient's medical and social needs, and
(8) It develops a hospice care program to meet those needs, and
(9) It provides ongoing quality assurance programs including reviews by physicians, other than those who own or direct the agency, and
(10) It permits all area medical personnel to utilize its services for their patients, and
(11) It keeps a medical record on each patient, and
(12) It uses volunteers trained to provide services for non-medical needs, and
(13) It has a full-time administrator, and
(14) It is a provider of services under Medicare with respect to Covered Family Members who are entitled to Medicare.

Hospice Facility means a facility which mainly provides hospice care and provides nursing services 24 hours a day under the direction of a Registered Nurse (RN) and meets any licensing or certification standards set forth by the jurisdiction in which it operates. It must employ a full time administrator, physician or RN and maintain complete medical records on each patient.

Hospital means a licensed institution that meets all the following requirements:

(1) It primarily provides, for compensation from its patients and on an inpatient basis, all facilities necessary for medical and surgical treatments, and care of injured and sick persons by or under the supervision of a staff of physicians, and
(2) It continuously provides 24-hour-a-day nursing service by registered professional nurses, and
(3) It is not a primary place for rest, a place for the aged, or a nursing home, and
(4) It is not primarily a place providing convalescent/skilled nursing care, rehabilitation care, Custodial Care, hospice care, treatment of Mental Illness or Substance Abuse, a health resort or spa, a sanitarium, an infirmary at any school, college or camp, and
(5) For Covered Family Members who are entitled to Medicare it means a facility that is a provider of services under Medicare, and
(6) It is accredited by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO).

Additionally, the following institution will qualify under this definition:

(7) A licensed birthing center that:
  (A) Provides care and treatment for Covered Family Members during uncomplicated pregnancy, routine full-term delivery, and immediate postpartum care, and
  (B) Provides full-time skilled nursing services, and
  (C) Is staffed and equipped to give Emergency care, and
  (D) Has a written arrangement with a local Hospital for Emergency care, and
  (E) Is a provider of services under Medicare with respect to Covered Family Members who are entitled to Medicare, and
  (F) Is approved for its stated purpose by the Accreditation Association for Ambulatory Care.

Hour of Service means each hour for which an Employee is entitled to payment by the Employer and for which the Employer is obligated by the terms of the Collective Bargaining Agreement to make contributions to the Fund. An Employee shall be credited with an Hour of Service for each hour worked regardless of the rate of those contributions. Hours of Service shall be credited according to the Remittance Reporting Periods pursuant to the Collective Bargaining Agreement.

Injury means an accidental loss, unforeseen impairment, or physical harm inflicted on the body by unexpected, external means.

Internal Adverse Benefit Determination or **Internal Adverse Determination** means any whole or partial denial of benefits, reduction of benefits, termination of benefits, or failure to provide or make benefit payment under the Plan. An Adverse Benefit Determination

includes, but is not limited to, amounts applied to the deductible, a Copayment, or a Coinsurance percentage payable by a Covered Family Member, or an amount applied as a penalty when Plan procedures are not followed. Adverse Determination also applies to a Covered Family Member's eligibility, the application of Pre-Certification the determination of an Experimental or Investigational treatment, and the determination of Medical Necessity.

Maintenance Care means continuing care that seeks to prevent disease, promote health, prolong life, and enhance the quality of life. There is also no evidence of improvement of the condition being treated, and the schedule of visits for care is not consistent with an acute pattern of treatment (e.g. every 2 to 4 weeks, or less frequently).

Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965, as amended from time to time.

Medical Services Team means an organization engaged by the Plan Administrator and/or the Claim Administrator for the purposes of providing utilization review and medical case management services for the Plan. In addition, the Medical Services Team will provide services as may be determined by the Plan Administrator or Claim Administrator.

Medically Necessary or **Medical Necessity** means health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

(1) In accordance with generally accepted standards of medical practice;
(2) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
(3) Not primarily for the convenience of the patient, physician, or other health care provider, and
(4) Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's illness, injury or disease.

"Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community when available, Physician Specialty Society recommendations, the views of prudent physicians practicing in relevant clinical areas, and any other clinically relevant factors.

Medicare means the program of medical care benefits for the aged and persons with disabilities provided under Title XVIII of the Social Security Act of 1965, as amended from time to time.

Mental Illness means a mental or an emotional disorder as defined and classified by appropriate ICD-10 coding, regardless of cause, which is characterized by an abnormal functioning of the mind or emotions and in which psychological, intellectual, emotional or behavioral disturbances are the dominating feature.

Network Provider means a Health Care Provider, Hospital, medical office or other Health Care Facility that has entered into an agreement to provide Covered Services at a predetermined rate.

Network Provider Reimbursement Schedule means the schedule of Allowable Expenses payable for any Covered Services by a Network Provider.

No Control means situations where you receive Treatment by an Network Provider or facility and a portion of that Treatment is rendered by an Out-of-Network Provider or facility. In those cases in which you had No Control over the Out-of-Network Provider who rendered care, the Out-of-Network Provider will be reimbursed based on the higher of the median Network negotiated rate, the Medicare rate, or the 85th Percentile of Reasonable and Customary rate. The Plan Administrator and/or Claims Administrator has the discretionary authority to decide whether the circumstance is out of the control of the Participant. Services could include, but are not limited to: a) anesthesiology services performed as an inpatient, outpatient or ambulatory setting; or b) Out-of-Network Provider inpatient services at an Network Hospital or Network free standing Surgical Facility.

Non-Emergency means the onset of symptoms that do not require Emergency care. The determination of what is considered a non-Emergency will be made by the Claim Administrator or Plan Administrator in their sole discretion.

Non-Occupational Disease means a Sickness which does not arise out of or in the course of any employment for compensation, profit, intent of profit, or self-employment, nor, in any way, results from a condition that does. However, if proof is furnished to the Claim

Administrator that an individual Covered under a workers' compensation law (or other law of similar purpose) is not Covered for a particular disease under such law, that disease shall be considered "non-occupational" regardless of its cause.

Non-Occupational Injury means an accidental bodily Injury that does not arise out of or in the course of any employment for compensation, profit, intent of profit, or self-employment.

Other Plan means arrangements of group insurance or group subscriber contracts (other than this Plan) through HMOs, Medicare or other government benefits, portions of group long-term care contracts, i.e. skilled nursing care, and other prepayment, group practice, and individual practice plans. Group-type contracts, through membership in a particular organization or group, which are not available to the general public, group hospital indemnity benefits in excess of $200 per day, and group or individual automobile “no-fault”, traditional “fault”, or tort type policies are also considered other plans. All provide medical, dental, or optical benefits or services on an insured, self-insured or an uninsured basis.

Other Plan does not include individual or family insurance policies, subscriber contracts, group or group-type hospital indemnity benefits of $200 per day or less, a state Medicaid Plan or CHAMPUS/TRICARE. Also, school accident-type coverage, which cover students of elementary and secondary schools or colleges for accidents on either a 24-hour around-the-clock, or a to-and-from-school basis are not included.

Out-of-Pocket Maximum means the most you could pay in a year for covered services. If you have other family members in this Plan they have to meet their own Out-of-Pocket Maximum until the overall family Out-of-Pocket Maximum has been met.

Not included in the Out-of-Pocket Maximum: premiums, balance-billed charges, penalty amounts and non-covered services.

Participation Effective Date means the earliest date on which coverage is first afforded to a Covered Family Member under this Plan.

Physical Rehabilitation Facility means a facility that it is not already part of an acute care Hospital that mainly provides therapeutic and restorative services. It must be accredited for its stated purpose by either the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) or the Commission on Accreditation for Rehabilitation Facilities (CARF). For Covered Family Members who are entitled to Medicare it means a facility that is a provider of services under Medicare for any Covered Family Member who is entitled to Medicare.

Plan means the Sheet Metal Workers Local No. 71 Healthcare Plan adopted and maintained pursuant to this document which sets forth the rights and obligations of the persons entitled to benefits under the Plan and the procedures by which Plan fiduciaries may be identified.

Plan Administrator means the person(s) appointed Plan Administrator pursuant to the procedures in the section entitled “Responsibilities of the Plan Administrator”.

Plan Year means the 12-month period beginning on January 1 and ending on December 31.

Post-Service Claim is a request for benefits made after the medical care or treatment has been provided to a Covered Family Member.

Pre-Certification, Pre-Certify, or **Post-Certification** means the process used when a claim for medical care requires the certification described in the section entitled “Utilization Management and Medical Review” including a request for an extension of care or concurrent care.

Pre-Service Claim means a request by a Covered Family Member for a benefit described in the section entitled “Utilization Management and Medical Review”. A Covered Family Member must contact the Claim Administrator prior to receiving the medical service or treatment. A Pre-Service Claim includes a claim that requires Pre-Certification, prior authorization, and benefits that include a penalty for failure to obtain prior authorization or Pre-Certification.

Privacy Officer means the person(s) designated by the Employer who is responsible for development, implementation, and compliance with the privacy policies and procedures as required by HIPAA.

Prior Plan means the Plan that was in effect directly prior to this Plan.

Protected Health Information (PHI) means any information that relates to any Sickness or Injury that is created, transmitted or maintained either orally, electronically, or on paper that identifies or could be used to identify a Covered Family Member.

Provider or **Health Care Provider** means an individual who is operating within the scope of his license to provide Medically Necessary Covered Services. A physician operating within the scope of his license and who is licensed to prescribe medications, administer drugs, perform surgery or to provide Medically Necessary Covered Services is a Health Care Provider.

Provider will also include services of a certified nurse practitioner when services are performed directly under the supervision of a physician, and skilled nursing services rendered by a registered professional nurse or by a licensed practical nurse under the direction of a registered professional nurse. Provider will also include a certified nurse midwife for any Covered Service that is within the lawful scope of their practice regardless of their employment status by a physician. A certified nurse midwife need not act pursuant to a physician's orders. Provider will also include a licensed dentist, or a licensed practitioner who is practicing within the scope of his license and whose license is favorably accepted by the State or other jurisdiction in which the Covered Services are provided. The term Provider will also include a physician's assistant, podiatrist, osteopath, optometrist, psychiatrist, psychologist, chiropractor, speech therapist, occupational therapist, or licensed physical therapist acting within the scope of his license or certificate who is performing services that are Covered by this Plan. When used in the treatment of Mental Illness, this term will also include a certified and registered social worker with at least six years of post-degree experience who has been qualified by the state in which they practice.

Qualified Medical Child Support Order (QMCSO) means any judgment, decree, or order (including approval of a property settlement agreement) issued by either a court of competent jurisdiction or through an administrative ruling that has the force and effect of state law. To be qualified, a QMCSO must satisfy the requirements of Section 609 of ERISA.

Reasonable and Customary means the smaller of:

(1) The charge usually made for the service by the Provider who furnishes it, or
(2) The prevailing charge made for the service, in the same geographic area, by Providers of similar professional standing, as determined by the Plan.

If the usual and prevailing charge for a service or supply cannot be easily determined because of the unusual nature of the service or supply, the Claim Administrator will determine to what extent the charge is a Reasonable and Customary charge, taking into account:

(1) The nature and severity of the condition, and
(2) The complexity involved, and
(3) The degree of professional skill required, and
(4) Any unusual circumstances which require additional time, skills or experience.

Reconstructive Surgery means surgery required because of trauma, infection or disease and a congenital disease or anomaly of a Covered Child which results in a functional defect. If a Covered Family Member requires Reconstructive Surgery to a breast following a Covered mastectomy procedure, the term Reconstructive Surgery will also include surgery to the opposing breast to produce a symmetrical appearance.

Reliable Evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Retiree means a person who has retired from the bargaining unit of Employees Covered by the Collective Bargaining Agreement and is receiving a pension from the Sheet Metal Workers Local No. 71 Pension Fund.

Sickness means an unhealthy condition of the body, a disease, a mental or physical disorder, or pregnancy. The term Sickness means all such Sicknesses due to the same or related causes, including all complications or recurrences. The term Sickness does not mean an Injury. Sickness will include voluntary sterilization of both males and females, but not the reversal of a voluntary sterilization. Sickness will include elective abortions.

Skilled Care means a service which we determine is furnished by or under the direct supervision of licensed medical personnel to assure the safety of the patient and achieve the medically desired results as defined by Medicare guidelines. A service is not considered a skilled service merely because it is performed or supervised by licensed medical personnel. However, it is a service that cannot be safely and adequately self-administered or performed by the average non-medical person without the supervision of such personnel.

Special Enrollment Period means a 30-day period, as mandated under the terms of the Health Insurance Portability and Accountability Act of 1996, during which an Employee and/or his Eligible Dependent(s) may enroll under this Plan if:

(1) Such individual had previously declined coverage under this Plan, was Covered under another health Plan, and involuntarily lost such other coverage, or
(2) The Employee acquires a new Dependent due to marriage, birth, adoption, or placement for adoption.

The Plan will also permit Employees and Dependents who are "Eligible but not enrolled" in the Plan a 60-day period to enroll in this Plan in the event of one of the following two circumstances:

(1) The Employee's or Dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility; or
(2) The Employee or Dependent become Eligible for a premium assistance subsidy under Medicaid or CHIP.

Standard Transaction means a transmission of information in a predetermined format between two or more parties to carry out financial or administrative activities related to the use and disclosure of Protected Health Information as required by the HIPAA Privacy Regulation.

Substance Abuse means the chronic abuse of alcohol or other drugs as defined and classified by the appropriate ICD-10 coding characterized by impaired functioning, debilitating physical condition, and the inability to keep from or reduce consumption of the substance, or the daily use of the substance in order to function. The term Substance Abuse includes addiction to alcohol or other drugs, but not caffeine, tobacco, or food.

Surviving Spouse or **Surviving Dependent** means a spouse or Dependent who is a Covered Dependent under this Plan on the date of an Employee's death.

Total Disability means that a Covered Family Member is prevented because of Sickness or Injury from engaging in any occupation on a total and continuous basis and is performing no work of any kind for compensation, profit, intent of profit, or self-employment. If a Dependent, the term means that he is prevented because of Sickness or Injury from engaging in substantially all of the normal activities of a person of like age and sex in good health. Additionally, if normally employed, the Dependent is not performing work for wage, profit, intent of profit, or self-employment, or engaging in any occupation on a total and continuous basis.

Treatment, Payment, or Health Care Operations means the medical, financial, or administrative activities required before the Plan can determine benefits including, but not limited to, the application of Standard Transactions, receipt of health care claims, health care payments, enrollment and disenrollment in the Plan, referral certification and authorization, and coordination or management of health care or related services by a Provider.

Trustees means the Board of Trustees of the Fund.

Union means the Sheet Metal Workers Local Union No. 71 its successor or assigns.

Urgent Care or **Urgent Care Claim** is a request for medical care or treatment that, if treated as non-Urgent Care could seriously jeopardize the Covered Family Member's life, health, or ability to regain maximum function. An Urgent Care Claim includes a request for medical care or treatment that would avoid subjecting the Covered Family Member to severe pain that cannot be adequately managed without the requested care or treatment.

The Plan will treat any claim as an Urgent Care Claim if a physician with knowledge of the Covered Family Member's medical condition determines that the claim involves Urgent Care.

An individual acting on behalf of the Plan may determine a claim to be an Urgent Care Claim by applying the judgment of a prudent layperson, possessing an average knowledge of health and medicine.

Urgent Care Facility means a medical facility that is open on an extended basis, is staffed by physicians to treat medical conditions not requiring inpatient or outpatient Hospital care, and which is not a physician's office.

ELIGIBILITY AND PARTICIPATION

This section explains the eligibility requirements and when coverage under the Plan begins and ends and shall apply to all benefits in this Plan.

WHEN COVERAGE BEGINS

Initial Eligibility for Employee: You are eligible to participate in the Plan on the first of the month following your first month of employment in Active Service in which you are credited with one-hundred (100) or more Hours of Service.

Reinstatement of Eligibility: If your coverage ends under the Plan and you return to work for a contributing Employer, you must satisfy the Initial Eligibility requirements as indicated above to reinstate coverage.

Continuing Eligibility: For Employees in Active Service

(1) **Continuing from Hours of Service:**

(A) An Employee in Active Service may remain covered under the Plan, for the month following each month in which they have accumulated 100 or more Hours of Service, provided they are working in Active Service or they are available to work in Active Service.

(2) **Continuing from Hour Bank:**

(A) If any Employee has more than 100 Hours of Service, Hours in excess of 100 hours will be recorded in an Hour Bank which can be used to extend coverage. The Hour Bank maximum balance will not exceed 600 Hours.

(B) Any month where the credited hours are less than the required 100 hour minimum, will result in having 100 hours deducted from your Hour Bank to maintain coverage for the following month.

(3) **Continuing from Disability Coverage:**

(A) If you do not have the 100 hours required to maintain coverage, your coverage will end and you will be offered to self-pay for your coverage in accordance with the COBRA provisions. In the event you become Disabled while you are covered under the medical Plan, you will receive coverage for each month following a month in which you qualify for the Disability Income Benefit for more than 14 days, and fail to work 100 hours due to the disability. This benefit is available for a maximum of six (6) months of coverage. In order to receive this coverage and maintain your eligibility, application for the Disability Benefit must be received by the Benefit Fund Office within 60 days of the date the disability began and must be approved by the Benefit Fund Office.

Maintaining Hour Bank Balance:

(1) If you lose your coverage because you have less than 100 hours in your Hour Bank, the remaining balance will be reinstated provided you remain in Active Service and meet the requirements for Reinstatement of Eligibility.

(2) If you are not able to return to Active Service at the end of Disability Coverage, your Hour Bank will be reinstated provided you return to Active Service within 6 months of the end of the Disability Coverage and you meet the requirements for Reinstatement of Eligibility.

(3) If you leave Active Service for any reason other than # 2 above, your Hour Bank balance will be forfeited.

Cost: Employee contributions, including co-pays and cost sharing, will be determined annually and may increase or decrease. Contributions will be based on claims the Plan experiences or other factors that the Plan Administrator deems relevant. Covered Family Members are responsible for any out-of-pocket expenses described in the Coverage Summary and services or supplies not Covered under the Plan.

Dependent Eligibility: All Eligible Dependents become Covered on the Employee's Participation Effective Date, provided that the Employee enrolls for family coverage. Dependents include the legal spouse of an Employee and the Child of an Employee. A Covered Child who becomes Totally Disabled will remain Covered during the time the Child is incapable of self-sustaining employment if the Employee submits proof of disability within 31 days of the date coverage would otherwise end.

Proof of Dependent Eligibility: The Trustees reserve the right to verify that your Dependent is Eligible or continues to be Eligible for coverage under the Plan. If you are asked to verify a Dependent's eligibility for coverage, you will receive a notice describing the documents that you need to submit. To ensure that coverage for an Eligible Dependent continues without interruption, you must submit the required proof within the designated time period. If you fail to do so, coverage for your Dependent may be canceled.

Enrolling for Coverage – Initial or Reinstatement of Eligible Employee: As a newly Eligible participant, you will receive enrollment information when you first become Eligible for benefits. To enroll in medical, prescription drug and dental coverage you will need to make your coverage elections by the deadline shown in your enrollment materials.

You will automatically receive identification (ID) cards for you and your Eligible Dependents when your enrollment is processed.

Adding Coverage during a Special Enrollment Period: An Eligible Employee may enroll for individual or family coverage during a Special Enrollment Period. The effective date of coverage will be the date the Employee acquires a new Dependent or the date the Employee or Dependent involuntarily lost coverage under another health Plan if the enrollment forms are completed during the Special Enrollment Period.

Special Enrollment. A Special Enrollment Period will be available for an Eligible Employee who either declined to enroll himself in the Plan when first Eligible to do so, or an Employee who enrolled in the Plan but declined to enroll his Eligible Dependents in the Plan when first Eligible to do so.

If you do not initially enroll within 30 days of your Initial Eligibility date or enroll during an Open Enrollment period, you and/or your Dependents may enroll at other times only if all of the following conditions are met:

(1) You and/or your Dependents were covered under another Plan or contract when coverage was initially offered;
(2) Coverage was provided in accordance with the continuation coverage required by state or federal law and was exhausted; or coverage under the other Plan or contract was terminated because you and/or your Dependents lost eligibility for one or more of the following qualifying events:
    (A) Termination of employment;
    (B) Termination of the other Plan or contract;
    (C) Death of the spouse;
    (D) Legal separation, divorce or annulment;
    (E) Reduction in the number of hours worked; or
    (F) The Contributing Employer or other group ceased its contribution toward the contribution for the other Plan or contract.
    (G) The Employee or Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP; and
    (H) You and/or your Dependents apply for coverage within the Special Enrollment Period after termination for one of the reasons set forth in Paragraph 2 above.
    (I) If you and/or your Dependents lost the other coverage as a result of failure to pay contributions or your coverage was terminated for cause (such as for fraud), you and/or your Dependents do not have Special Enrollment rights.

The Plan will also permit Employees and Dependents who are "Eligible but not enrolled" in the Plan a 60-day period to enroll in this Plan in the event of one of the following two circumstances:

(1) The Employee's or Dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility, or
(2) The Employee or Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

Enrollment due to changes in Employee or Dependent status or as a result of special circumstances (as defined in the section entitled "Special Enrollment Period") is effective as of 12:01 a.m. on the first of the month following the date of the event. Birth of a Child is effective at 12:01 a.m. as of the date of the event.

To Add a Spouse. You and your spouse must fill out and return an enrollment form, any requested documentation, and any required contribution to the Fund Office. If you return the completed forms, requested documentation and required contribution within 30 days of the marriage, your spouse will be added to your coverage effective the first of, or coinciding with, the first of the following month. If you do not, your spouse may be added to your coverage during the next Open Enrollment Period provided the Benefit Fund Office receives the required open enrollment forms and documentation.

To Add a Child.

(1) You must complete and return an enrollment forms, any requested documentation, and the required contribution. If you do so within 30 days of the date of birth, adoption, placement for adoption, or within 30 days of the date the child became

your stepchild, your Child will be added to your coverage. Your Child will be Covered effective as of the date of birth, adoption, or placement for adoption. Your Stepchild will be added to your coverage effective the first of, or coinciding with, the first of the following month. If you do not enroll within 30 days of the events described, you can enroll your Child to your coverage during the next Open Enrollment Period when the Plan Administrator receives the completed forms, requested documents and applicable contribution.

When adopting a Child, no coverage shall be provided for the birth expenses of the natural mother or any medical care or treatment of the newborn prior to actual, physical birth and delivery of the newborn. Until such time as the adoption process is complete, coverage for the adoptive Child under this Plan will always be secondary to the coverage provided by any governmental program, (including Medicare, Medicaid, etc.) or to coverage available from the natural parents.

If a notice of revocation of adoption is filed or one of the natural parents revokes their consent to the adoption, the Plan will be entitled to recover the amount of benefits provided by the Plan.

(2) To add a child for whom a court has ordered you to provide dependent health insurance coverage pursuant to a Qualified Medical Child Support Order you must mail the Plan Administrator a copy of the order, by first class mail, postage prepaid. The Plan Administrator will make a determination as to whether the order is a Qualified Medical Child Support Order and notify you and the affected children of the determination, in writing, within 15 days of receipt of the order. If the child is otherwise Eligible for coverage, the Plan will enroll the child as of the date of the Plan Administrator's determination.

Annual Open Enrollment
Each year during a designated open enrollment period, you will be given an opportunity to make your elections for the upcoming year. Your open enrollment materials will provide the options available to you. Changes to your elections will take effect on the following January 1 and stay in effect through December 31, unless you have a qualifying change in status.

Failure to Report Enrollment Changes: Enrollment changes must be submitted to the Plan Administrator. Failure to report such changes could result in incorrect payment of Plan benefits. Should this happen, you may be required to reimburse the full amount of any benefit overpayment.

WHEN COVERAGE ENDS

Employee Coverage Ends: Employee coverage terminates on the earliest of the following:

(1) The date the Plan is discontinued, or
(2) The date the Employee no longer satisfies the eligibility requirements, or
(3) The date the Employee withdraws from Active Service, or
(4) The date the Employee ceases to be an Employee under the Plan.

Dependent Coverage Ends: Dependent coverage will terminate on the earlier of:

(1) The date the Plan is discontinued, or
(2) The date the Employee's eligibility or coverage under the Plan terminates, or
(3) The last day of the month in which the Dependent no longer qualifies as a Dependent, or
(4) The date the Dependent becomes a Covered Employee and elects to enroll under the Plan (except a Dependent Student hired temporarily during vacation periods), or
(5) The date all Dependent coverage is discontinued under the Plan, or
(6) The date the Employee ceases to be included in the class of Employees Eligible for Dependent coverage, or
(7) The last day of the month for which the Employee has made the required contribution, if any, toward the cost of Dependent coverage.

When your coverage terminates under this Plan, you and your Covered Dependents may be Eligible to continue coverage under "COBRA" as described in the section entitled "Continuation of Coverage".

Prohibition on Rescissions: The Affordable Care Act prohibits a group health plan from rescinding health coverage except in the case of fraud or intentional misrepresentation of a material fact. The prohibition on rescissions applies to plans and insurers (including grandfathered plans) for Plan years beginning on or after September 23, 2010.

The Regulations define rescission as a cancellation or discontinuance of coverage that has retroactive effect. A cancellation or discontinuance is not a rescission if it has prospective effect, or if it is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. The Regulations also require that a group health Plan provide at least 30 days' advance written notice to each participant who would be affected before coverage may be rescinded, regardless of whether the rescission applies to an entire group or only to an individual within the group.

SURVIVING SPOUSE AND SURVIVING DEPENDENT COVERAGE: In the event of an Employee's death while Covered by the Plan, the Employee's Surviving Spouse or Surviving Dependents may be Eligible to continue their coverage under "COBRA" as set forth below. If an Employee's Dependents continue coverage under "COBRA", their coverage under this Plan will terminate as described under "Continuation of Coverage".

CONTINUATION OF COVERAGE

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 - COBRA
FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)
UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

This section contains a brief explanation of the Federal laws that permit a Covered Family Member to continue healthcare coverage under the Plan. If you lose coverage under the Plan, contact the Plan Administrator at the address and telephone number in the section entitled "General Plan Information". The Plan Administrator is available to provide a complete description of your right to continue coverage under COBRA, FMLA, or USERRA. Coverage will be identical to that provided by the Plan. Proof of good health is not required in order to continue coverage.

Eligible COBRA Beneficiaries: An Employee or any Covered Family Member who loses coverage under the Plan will be considered an Eligible COBRA Beneficiary unless the Employee was terminated due to gross misconduct. An Eligible COBRA Beneficiary includes a new Dependent or a Child who is born or placed for adoption with a COBRA Beneficiary. The new Dependent may be enrolled during the Special Enrollment Period by timely notifying the Plan Administrator.

If an Employee loses Plan benefits due to termination of employment or a reduction in hours, Covered Family Members may continue coverage for up to 18 months by paying the cost of coverage plus any additional amounts set by law. A COBRA Beneficiary may change coverage (individual or family) as described in the subsection entitled "Eligibility and Participation".

A COBRA Beneficiary may be determined totally disabled under Title II or Title XVI of the Social Security Act after enrolling for COBRA coverage. If the Social Security Administration determines that a COBRA Beneficiary was disabled on the date of the qualifying event or within the first 60 days of COBRA coverage, the disabled COBRA Beneficiary and Family Members who are receiving COBRA coverage in connection with the same qualifying event may continue coverage for up to 29 months by paying the cost of coverage plus any additional amounts set by law. The disabled COBRA Beneficiary must apply for and be approved for Social Security Disability benefits. Family Members who are not disabled may elect to extend coverage even if the disabled COBRA Beneficiary declines to do so. Notify the Plan Administrator by mailing a copy of the Social Security determination to the address in the section entitled "General Plan Information". The disabled COBRA Beneficiary must notify the Plan Administrator within 60 days of the Social Security determination and before the end of the 18-month COBRA period.

When a Dependent is Eligible for COBRA: A Covered Dependent becomes an Eligible COBRA Beneficiary if they lose coverage under the Plan. A Covered Dependent can continue coverage up to 36 months if one of the following qualifying events occurs:

(1) A Child is no longer Eligible as a Dependent (or Dependent Student). The Covered Family Member must notify the Plan Administrator within the later of 60 days of this qualifying event or 60 days of the loss of coverage.
(2) A spouse is no longer Eligible as a Dependent because of a legal divorce, a legal annulment, or a legal separation. The Covered Family Member must notify the Plan Administrator within 60 days of this qualifying event.
(3) An Employee dies. The Employer is responsible for notifying the Plan Administrator no later than 30 days after this qualifying event.
(4) An Employee becomes enrolled in Medicare while Covered by COBRA. The Employer is responsible for notifying the Plan Administrator no later than 30 days after this qualifying event.

If a second qualifying event described above occurs during the first 18 months of COBRA coverage, the maximum period of continued coverage will be 36 months from the date of the original qualifying event. If you fail to notify the Plan Administrator within 60 days

of a Qualifying event that causes a Dependent to lose Eligibility (qualifying events 1 and 2 above) the Covered Family Member will lose all rights to continue coverage as an Eligible COBRA Beneficiary.

When Coverage may not be continued: An Employee or other Covered Family Member who loses coverage when an Employee terminates Active Service due to gross misconduct may not continue coverage under COBRA. The Plan Administrator will send a written notice to the Employee and any other Covered Family Member to explain why the Family Members are not Eligible to continue coverage.

When Continued Coverage Ends: Continued coverage will end for any person when:

(1) The cost of continued coverage is not paid when it is due, or
(2) That person becomes enrolled in Medicare after their COBRA election date under this Plan, or
(3) That person becomes Covered under any other health plan after their COBRA election date under this Plan, or
(4) The Plan terminates for everyone, or
(5) The maximum period of extension under this provision ends (18, 29, or 36 months).

If the period of continued coverage was extended from 18 to 29 months due to a person's entitlement to Social Security disability, coverage for that person and for all COBRA Beneficiaries who were entitled to the disability extension will end as of the first of the month beginning 30 days after the date the Covered Family Member is no longer disabled. The person receiving extended coverage as a disabled COBRA Beneficiary is responsible for notifying the Plan Administrator (within 30 days of the Social Security determination) that he or she is no longer disabled.

When continued coverage terminates earlier than the 18, 29, or 36 months described above, the Plan Administrator will send a written notice to any Covered Family Member to explain why COBRA coverage terminated early.

Notice Requirements: If an Employee becomes Eligible for COBRA, the Plan Administrator will notify each Covered Family Member of their right to continue coverage and the cost. The Plan Administrator will also notify each Covered Family Member of their right to continue coverage and the applicable cost in the event of an Employee's death or enrollment in Medicare.

Each Covered Family Member has an independent right to elect COBRA coverage, even if an Employee rejects COBRA coverage. The Employee or Covered Family Member must request continued coverage within 60 days from the date they are provided written notice of their eligibility to elect COBRA continued coverage. Any election (or rejection) of continued coverage may be changed for any reason during the 60-day election period. Failure to elect COBRA during the 60-day election period will result in the loss of all rights to continue coverage for the benefits available under this Plan.

If a spouse loses coverage due to a divorce, a legal annulment, or a legal separation, or if a Child loses coverage because the Child no longer qualifies as a Dependent, the Employee, spouse or Dependent must notify the Plan Administrator within 60 days of the Qualifying event if they wish to continue coverage. Notify the Plan Administrator at the address in the section entitled "General Plan Information". Failure to notify the Plan Administrator within 60 days of the Qualifying event will result in the Covered Family Member losing all rights to continue coverage under this Plan.

It is very important to keep the Plan Administrator informed of the current address of all participants and beneficiaries who are or may become qualified COBRA Beneficiaries. You may notify the Plan Administrator at the address in the section entitled "General Plan Information".

The Employer is required to notify the Plan Administrator of the following qualifying events:

(1) The Employee's loss of coverage due to termination of employment, other than by reason of gross misconduct.
(2) An Employee's loss of coverage due to a reduction in hours.
(3) The death of the Employee.
(4) The Employee's entitlement to Medicare.

Cost of Continued Coverage: Any person who elects to continue coverage under the Plan must pay the full cost of the coverage plus any additional amounts set by law. If election is made after the Covered Family Member becomes Eligible for COBRA, the first payment must reach the Employer within 45 days of the election. It must cover the entire period prior to the election. There is a 30-day grace period allowed for subsequent payments. The cost of the continued coverage will be determined by a method defined by law. Calculation of COBRA premiums is made annually and may increase or decrease based on Plan experience.

Trade Act of 2002: An Employee whose loss of coverage qualifies for the Health Coverage Tax Credit will receive assistance with the cost of continued coverage. The loss of job must be due to trade-related reasons certified by the Department of Labor under the Trade Act of 2002.

Employees who qualify for assistance under the Trade Act of 2002 will also qualify for a second 60-day period to elect COBRA continuation coverage if the Employee is determined to be Eligible for trade adjustment assistance after they lose coverage. The second 60-day election period will begin on the first day of the month in which a worker becomes Eligible for federal trade adjustment assistance but the election period may not extend beyond six months after the initial loss of group health plan coverage.

If an Employee elects COBRA coverage during the second election period, coverage will begin on the first day of that second election period. There is no retroactive COBRA coverage for the gap between the initial loss of coverage and the first day of the second election period.

The second COBRA election period does not extend the original COBRA benefit period, which is still measured from the date of the loss of coverage due to the qualifying event.

If you have any questions about the Trade Act, you may call the Health Coverage Tax Credit Consumer Contact Center at (866) 628-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

FMLA and New York Paid Family Leave. If you are eligible for, and are granted leave by your Employer under the Family and Medical Leave Act of 1993, (the "FMLA") and/or the New York Paid Family Leave Law (the "NYPFLL"), and you have worked 100 hours of service under the Collective Bargaining Agreement in the month prior to your leave, you will be entitled to health and hospitalization insurance coverage under the Plan for the first month of your leave. Thereafter, your Employer must contribute to the Plan a monthly premium equal to the required contribution for up to 100 hours of service if necessary for your coverage to continue. You will receive the type of coverage (i.e., family or single) you were receiving prior to the leave, subject to any change you may have in family status.

If you fail to return to work after a period of unpaid FMLA leave entitlement has been exhausted or expires, your Employer is entitled to recover the premiums paid on your behalf unless the reason you did not return is due to a continuation, recurrence, or onset of a serious health condition which entitles you to leave under the FMLA, or other circumstances beyond your control as defined in the FMLA and the regulations thereunder. Questions regarding your entitlement to FMLA or NYPFLL leave should be referred to your Employer. Questions about the continuation of medical and dental coverage during leave, if available, should referred to the Fund Office.

If you do not return to work at the end of an FMLA or NYPFLL leave, you may be entitled to elect COBRA Continuation Coverage, even if you were not covered under the Plan during the leave. Coverage continued under this provision is in addition to coverage described above under the section entitled Continuation of Coverage.

USERRA Continuation Coverage. If you are covered by the Plan and enter the United States Armed Forces (including the United States Armed Forces, the Coast Guard, the Army National Guard, the commissioned corps of the Public Health Service, and certain other categories of service), you may be entitled to continue your (and your Dependent's) health coverage under the Plan during your military service.

If you choose to continue coverage for the length of your Service in the Uniformed Services you will be required to pay the COBRA premium under the Plan. You will not be required to pay such premium if your length of service is less than 31 days. For detailed information on premium amounts and application for such coverage, please contact the Fund Administrator. You can receive this self-pay coverage for a period of up to 24 months total (or, if earlier, until the day after the date you fail to apply for or return to covered employment). Payments would generally need to be made under the same procedures required for COBRA premiums.

Separation from uniformed service that is dishonorable or based on bad conduct, on grounds less than honorable, AWOL, or ending in a conviction under court martial would disqualify you from any rights under USERRA. Please contact the Fund Office for more information regarding your options under USERRA.

COORDINATION OF BENEFITS

This coordination of benefits provision applies to the payment of benefits provided in this Plan and another Plan. If you and your Dependents are Covered under more than one health plan, the plans will coordinate the payment of benefits.

The Covered Family Member will receive the maximum benefit allowed including Coinsurance, Copayments and deductibles. The calculation of benefits payable for an Allowable Expense will be made by the Claim Administrator based on the Reasonable and Customary charge, any scheduled benefit, or by reviewing any negotiated (including Network provider) fee schedules. The following rule will apply whenever a determination of an Allowable Expense must be made under this section:

(1) When one plan determines an Allowable Expense by means of a reasonable and customary charge and the Other Plan(s) determines it by a different means, an Allowable Expense will be determined by the plan that is determined to be primary under this section.

(2) When both plans determine an Allowable Expense by the same means (as a reasonable and customary charge or by means of the same schedule mentioned below) the determination of an Allowable Expense will not include any amount in excess of:
   (A) Both plans' highest reasonable and customary charge, or
   (B) Both plans' highest scheduled benefit, or
   (C) Both plans' highest negotiated (Network provider) fee schedule.

The Claim Administrator will calculate any benefit payable to a Covered Family Member based on the per claim method. Under this method for coordination of benefits, the maximum benefit payable to the Family Member for Covered Services is limited to 100% of the Allowable Expense on a per claim determination basis.

When Coordination of Benefits Applies: The plans coordinate the payment of claims for benefits and one of the plans pays the claim as the primary plan and the Other Plan pays the claim as the secondary plan. The primary plan pays benefits first. The secondary plan then coordinates the payment of the claim for benefits, up to the total Allowable Expense. No single plan will pay more than it would have paid without the coordination of benefits provision. A plan that has no coordination of benefits provision is automatically the primary plan.

When this Plan is determined to be the primary plan, the benefits of the Other Plan will be ignored for the purpose of determining the benefits payable under this Plan.

When this Plan is determined to be the secondary plan, the Claim Administrator will determine what expense is an Allowable Expense. Benefits payable under the Other Plan include the benefits that would have been payable had a claim been made for them. Under no circumstance will this Plan pay more than would have been paid had this Plan been the primary plan.

The coordination of benefit calculation will be made for each claim. No recalculation of benefits will be made for charges included in a prior claim.

The plan primarily responsible for payment of benefits is determined in the following order:

(1) A plan that does not contain a coordination of benefits provision pays first.

(2) Benefits available through state-mandated automobile fault, no-fault or tort insurance are primary over any benefits payable under this Plan.

(3) The plan that covers a person as an active Employee is primary over a plan that covers that person as a retired Employee, COBRA Beneficiary, or Dependent.

(4) The Plan that covers a person as a retired Employee:
   (A) Is primary over the plan covering that person as a COBRA Beneficiary or Dependent, or
   (B) If Eligible for Medicare, the Medicare Secondary Payer (MSP) rules are controlling. This means that the primary plan is the plan covering the person as a Dependent of an active person, Medicare would be secondary, and the retiree plan would pay last unless a superseding Medicare Secondary Payer rule would control.

(5) Except as stated in paragraph (6) below, if this Plan and an Other Plan cover the same Child as a Dependent of different persons called "parents," the plan of the parent whose birthday falls first in the year will be primary over the plan of the parent whose birthday falls second in the year. Birthday means month and day, not the year. If both parents have the same birthday, benefits for the plan that Covered a parent longer are determined before those of the plan that Covered the other parent for a shorter period of time. This also applies when the parents are not divorced or legally separated, whether or not they have ever been married.

(6) If two or more plans cover a person as a Dependent Child of divorced or separated parents, whether or not the parents were ever married, benefits for the Child are determined as follows:
   (A) First, the plan of the custodial parent of the Child;
   (B) Second, the plan of the spouse of the custodial parent of the Child;

(C) Third, the plan of the non-custodial parent of the Child;

(D) Last, the plan of the spouse of the non-custodial parent of the Child.

(E) However, if the terms of a Qualified Medical Child Support Order (QMCSO) or other court order state that one of the parents is responsible for the health care expenses of the Child, the benefits of that plan are determined first. When the specific terms of a QMCSO state that the parents shall share joint custody, but do not specify which parent has financial responsibility for the health care expenses of the Child, the Plan will determine primary coverage by the birthday rule. If the responsible parent named in the QMCSO does not have health care coverage for the Dependent Child, but that parent's spouse does have coverage for that Child, then the spouse's plan will be primary.

(7) When the above rules do not establish an order for the coordination of benefits, the plan that Covered the person longer will be primary.

When a claim is submitted on behalf of any Covered Family Member, the Claim Administrator will need all information about any Other Plan providing coverage. The Claim Administrator has the right to release or obtain any related information and make or recover any payments it considers necessary to administer these provisions.

When medical coverage under an Other Plan is primary and the coverage under this Plan is secondary, submit any claim to the Other Plan first. Then, submit a copy of the "explanation of benefits" from the Other Plan when submitting the claim to the Claim Administrator of this Plan.

Effect on Benefits: If this Plan pays less than it would otherwise pay due to this coordination of benefits provision, only the reduced amount is applied to any maximum benefit limit described in the Coverage Summary. This Plan will not consider any charge in excess of what an HMO Provider or Network Provider has agreed to accept as payment in full.

Continuation of Coverage: A Covered Family Member may elect continuation of coverage under a right of continuation according to Federal law and also have coverage under an Other Plan. When coordination of benefits applies, the benefits of a plan that covers the Family Member as an Employee, subscriber or retiree (or as the Dependent of that Family Member) will be determined first. The benefits under continuation of coverage will be determined second.

When a Managed Care Plan is the Primary Plan: If a managed care plan or health maintenance organization (HMO) Plan is the primary plan for a Covered Family Member and the Family Member elects to ignore its provisions, exclusions, or limitations, or chooses to go outside the Other Plan for treatment, this Plan will not accept liability or coordinate benefits for the charges not Covered by the Other Plan.

Right to Receive and Release Necessary Information: The Claim Administrator has the right to receive or release any information considered necessary to administer these coordination of benefits provisions.

Right of Recovery: When the Plan pays benefits that should have been paid by an Other Plan, this Plan's Claim Administrator may recover any amount paid, either from the Other Plan or from the Covered Family Member. That recovery will count as a valid payment under the Other Plan.

When it is determined that an overpayment was made, the Claim Administrator may recover the overpayment from the source to which it was paid. An overpayment is any benefit payment that exceeds the Allowable Expense.

THE EFFECT OF MEDICARE

The Plan will determine Medicare related benefits according to the provisions in this section when a Covered Family Member is Eligible for Medicare.

Eligibility for Medicare: A Covered Family Member is Eligible for Medicare when:

(1) The Covered Family Member has coverage under Medicare, or

(2) The Covered Family Member qualifies for coverage under Medicare, but has refused, discontinued, or failed to apply for Medicare coverage.

In order for an expense to be Covered under this section it must be a Medicare Allowable Expense.

The Effect of Medicare Secondary Payer Rules: The Medicare Secondary Payer Rules require that this Plan be the primary payer of benefits for the following Covered Family Members who are also Eligible for Medicare:

(1) A Covered Employee in Active Service, including any individual on short term or long term disability for up to six months while that individual is an Employee, and

(2) The Covered Dependent of an Employee in Active Service if the Dependent is also Covered by Medicare.

This Plan will be the primary payer of medical expense benefits for a Covered Family Member who is also Covered by Medicare unless the Employee or Dependent chooses to terminate coverage under this Plan and elects Medicare as the primary payer of medical expense coverage. But if the Employee elects Medicare as the primary payer of medical expense coverage, the Employee's medical benefits under this Plan will cease. If a Covered Dependent elects Medicare as the primary payer of medical expense coverage, the Dependent's medical benefits under this Plan will cease.

If an Employee is Eligible for Medicare prior to becoming Eligible for COBRA coverage, Medicare will be the primary payer.

When a Covered Family Member is Eligible for Medicare due to end stage renal disease (ESRD) this Plan will be the primary payer for the first 30 months unless the Covered Family Member was already entitled to Medicare coverage as primary on the basis of age or disability and no other Medicare secondary payer rule applies. Medicare will be the primary payer of benefits after the first 30 months.

Regardless of any other provisions of this section, the Plan will be secondary to Medicare to the extent permitted by applicable law, and under no circumstances will the Plan pay more than its regular benefit.

When Medicare is the Primary Payer: When Medicare is primary payer of medical expense benefits the amount of health expense benefits payable will be calculated using the Per Claim Coordination of Benefits method.

This means the Plan will coordinate benefits with Medicare being the primary payer and this Plan's benefits will be secondary to Medicare benefits on a per claim basis. Any expense that is not Covered by Medicare but is a Covered Service under the Plan will be determined according to the provisions of the Plan.

When Medicare does not pay a claim because the Covered Family Member refused, discontinued, or failed to apply for Medicare coverage, the Claim Administrator will estimate the amount of benefit Medicare would have paid on a non-discriminatory basis. The Claim Administrator's estimate will be used to determine the amount of any benefit payable for a Covered Service under this Plan.

Any benefits payable as calculated above will be determined before benefits are coordinated with any Other Plan. A benefit calculation will be made for each claim. No recalculation of benefits will be made for charges included in a prior claim based on that prior calculation of benefits.

Medicare Assignment: Assignment is an agreement between Medicare, physicians, suppliers and other health care providers who agree to accept the Medicare approved amount as payment in full for services. The Medicare Covered Family Member is only responsible to pay the Medicare deductible and Coinsurance amounts. Physicians, suppliers and other health care providers who have agreed to accept assignment from Medicare are not permitted to bill or collect from the Medicare Covered Family Member an amount that is over Medicare's approved amounts. This Plan will not cover any services in excess of the Medicare approved amount.

Some physicians, suppliers and other Health Care Providers do not accept Medicare assignment. Federal law limits the charges Medicare will reimburse when certain Providers refuse assignment to 15% over the Medicare-approved amount (called a limiting charge). When a limiting charge is applied to a Provider who does not accept Medicare assignment, the Provider is not allowed to bill or collect from the Covered Family Member any amount that is over the Medicare limiting charge. This Plan will not reimburse those Providers for any Covered Service in excess of Medicare's limiting charge.

SUBROGATION/REIMBURSEMENT PROVISION

The Plan does not provide any coverage with respect to any accident, Sickness or Injury for which any party may be liable or legally responsible. If a Covered Family Member receives or expects to receive any payment from any source for expenses resulting from such accident, Sickness or Injury, you should not submit a claim for benefits under this Plan. Any such recovery will be deemed as compensation for medical expenses. Payment made by the Plan for any such accident, Sickness or Injury would be considered an overpayment and the Plan will seek reimbursement for such overpayment. The Plan, at its discretion, may authorize Plan benefits for

expenses that would otherwise be Covered by the Plan. Any such payments are subject to the Plan's subrogation or reimbursement rights.

The Covered Family Member is required to notify the Plan Administrator within 10 days of any accident, Sickness or Injury for which someone else may be liable. The Plan Administrator must also be notified within 10 days of the initiation of any lawsuit arising out of the accident, Sickness or Injury and the conclusion of any settlement, judgment or payment relating to the accident, Injury, or Sickness in any lawsuit to protect the Plan's claims.

Subrogation Right: Subrogation conserves Plan benefits by keeping a Covered Family Member from profiting by a double recovery for a Covered Service. As a condition for receipt of benefits under this Plan, Covered Family Members must agree to promptly reimburse the Plan first, before any other party is paid, if a Covered Family Member recovers any money damages for the accident, Sickness or Injury regardless of how the recovery is characterized, including damages for malpractice, from any other party on account of such accident, Sickness or Injury. The Plan Administrator has, to the extent of the full cost of any Covered Service paid under this Plan, a subrogated right to the Covered Family Member's recovery from such party.

The reimbursement required under this provision:

(1) Applies even if the total recovery is less than the losses incurred as a result of the accident, Sickness or Injury suffered by the Covered Family Member has been fully compensated, or *"made whole",* by their recovery. This Plan specifically rejects the application of the made whole doctrine, and

(2) Will not be reduced to reflect any of the costs of attorney's fees and disbursements incurred in obtaining such judgment or settlement, unless separately agreed to, in writing, by the Plan Administrator in the exercise of its sole discretion, and

(3) Applies regardless of whether such funds are earmarked for pain and suffering or any other form of non-economic loss.

Conditional Benefit Payment: The Claim Administrator may provide benefits when a Covered Family Member receives a Covered Service. However, before such benefits are conditionally made, the Covered Family Member will be required to execute and timely deliver such documents or take such other action as is necessary to fully assure the rights and remedies of the Plan Administrator.

This right of subrogation allows the Plan to pursue any claims which the Covered Family Member has against any party, or insurer, whether or not the Covered Family Member chooses to pursue that claim.

The failure or refusal of the Covered Family Member to cooperate with and assist the Plan in pursuit of its right to subrogate any party claims may result in the forfeiture and termination of his entitlement to continue coverage under this Plan.

Subrogation under this section specifically does not apply to an individual health insurance policy that the Covered Family Member may have in force.

Subrogation Agreement: Once it has been determined that any party may be liable in any way for the accident, Sickness or Injury you are required to provide in writing any expense for which any party may be liable. The Covered Family Member, Authorized Representative if a minor or unable to sign, or his or her legal representative, must execute and provide timely delivery of documents, notices or papers as may be required and must do whatever else is needed to secure the rights of the Plan, including the following:

(1) The Covered Family Member or legal representative must agree, in writing, to provide the Claim Administrator with written notice whenever a claim is asserted or could be asserted against, and/or receipt of funds from any party for damages as the result of accident, Sickness or Injury, and

(2) The Covered Family Member or legal representative must agree, in writing, on a form acceptable to the Claim Administrator, to reimburse the Plan at 100% for any benefits, past, present or future, paid on your behalf for any such accident, Sickness or Injury. This reimbursement can be from any settlement, judgment, or other payment that you obtain from the liable party, before any expenses are taken out, including but not limited to, attorney's fees and court costs, and

(3) The Covered Family Member or legal representative of a minor Dependent must provide, in writing, an assignment of benefits or a lien against such proceeds, in favor of the Plan in the amount of any benefits paid by the Plan due to such accident, Sickness or Injury. The assignment of benefits will be valid against any judgment, settlement, or recovery that is or will be received from any party, and

(4) The Covered Family Member receiving benefits further agrees that any funds received by the Covered Family Member or their attorney, if any, from any source for any purpose shall be held in trust until such time as the obligation under this provision is fully satisfied, and

(5) The Covered Family Member will be responsible for the Plan's court costs and attorney's fees if the Plan needs to file suit to recover

payments of expenses previously paid by the Plan.

RIGHT OF REIMBURSEMENT AND ASSIGNMENT OF PROCEEDS: THIRD-PARTY LIABILITY

The term "Third Party" means a person or organization other than the Covered Family Member. No benefits shall be paid under any coverage of this Plan with respect to any Injury or illness for which a Third Party may be liable or legally responsible. However, subject to the provisions of this Section, the Plan will pay such benefits provided that the Covered Family Member (or his legally authorized parent, guardian, or representative) shall comply with the following conditions:

GENERAL

Occasionally, a third party may be liable for a Participant's medical expenses. This can occur when the third party is responsible for causing the Participant's illness or Injury. The rules in this section govern how the Plan pays benefits in such situations. The rules have two purposes. First, the rules insure that a Participant's medical bills will be paid promptly. Often, where there is a question of third party liability, many months pass before the third party actually pays. These rules permit the Plan to pay medical bills until the Participant's dispute with the third party is resolved.

Second, the rules protect the Plan from bearing the full expense in situations where a third party is liable. Under these rules, once it is determined that a third party is liable for medical bills advanced by the Plan, the third party (or the Participant) reimburses the Plan for the benefit payments it advanced.

LIEN REQUIRED

If a Participant has medical or other expenses for which a third party may be liable, the Participant is obligated to advise the Plan, and to sign the Plan's lien forms before the Plan pays benefits on those expenses. The lien form creates an equitable lien in favor of the Plan with respect to 100% of the benefits it has paid or may become obligated to pay for the Participant's expenses, and requires that the funds recovered are Plan assets to be held in a separate identifiable fund constituting a constructive trust subject to an equitable action by the Plan under ERISA §502(a)(3).This means that the Plan must be reimbursed on a first priority basis, from any settlement, judgment, or other payment obtained from the liable third party, prior to payment of any attorney's fees out of the settlement, without application of the "make whole" "common fund" or any similar doctrine, and without regard to whether the parties in any third-party action characterize the proceeds as representing medical expenses, punitive damages, or "pain and suffering" compensation. The Plan specifically rejects the "make-whole" and "common fund" doctrines.

In such a situation, no Plan benefits are paid (and the Plan does not become obligated to pay benefits to providers) unless the Participant, and his attorney (if any) sign the form. Signing the form is a condition precedent to the Fund's liability for payment of covered benefits. In the event the Participant commences litigation against the third party, he grants the Plan the right to receive updates from his attorney on the progress of the litigation.

FAILURE TO DISCLOSE

If the Participant fails to tell the Plan that he has a claim against a third party, and fails to reimburse the Plan out of the payment he obtained from the third party, the Participant is liable to the Plan for the reimbursement. The Plan may offset the amount owed from future benefits, or, if necessary, take legal action against the Participant. If legal action is required, the Participant will also be liable for the Plan's attorney's fees and other expenses of the litigation.

EXAMPLE

The following example illustrates the application of this provision. Participant "A" is injured in an automobile accident, and incurs medical expenses which are covered by the plan. "A" hires an attorney, who takes the case on a 30% contingency fee basis. In keeping with Plan provisions, "A" and his attorney execute the Plan's Lien form, and proceed with a civil action against the party who caused the accident. The Plan becomes obligated to pay medical expenses for "A" of $25,000. The case is settled for $100,000. The proceeds, to the extent of the plan's lien, are considered to be "plan assets". In this example, the Plan is reimbursed the full $25,000 it is obligated to pay before any money is disbursed to "A" or his attorney, and without reduction for any portion of attorney's fees. The remaining $75,000 if the settlement is allocated between "A" and his attorney pursuant to their agreement. In this example, the attorney would receive 30% of the recovery, ($30,000), and "A" would receive the remaining $45,000. Note also that "A" received the benefit of the $25,000 reimbursed to the Plan, since the Plan paid his medical expenses.

If "A" and his attorney had not signed the Lien, the Plan would have paid nothing, and the medical expenses would have been paid out of the proceeds of the recovery. Participant "A" would have been in the same financial situation with respect to the plan.

The conditions herein set forth shall not apply to any benefits payable under Medicare Supplementary coverage, nor to any amount received by the Covered Family Member under any other insurance policy or certificate issued to the Covered Family Member or to any Dependent of any Employee covered hereunder.

The amounts to be recovered by the Plan pursuant to the provisions hereof shall not be reduced by any attorney's fees, court costs, or other disbursements.

UTILIZATION MANAGEMENT AND MEDICAL REVIEW

Pre-Certification: The process by which the Plan's Medical Services Team evaluates a Pre-Service Claim is defined as Pre-Certification. A Covered Family Member must Pre-Certify the following Covered Services:

(1) Alcohol/Substance Abuse (including Inpatient Facility Detoxification and Inpatient Rehabilitation)
(2) Chemotherapy
(3) Clinical Trials
(4) Cosmetic Reconstructive Surgery – failure to pre-certify will result in a denial to Plan Participant
(5) Dental (Accidental, Congenital Disease and Anomaly)
(6) Durable Medical Equipment
(7) Experimental/Investigational
(8) Genetic Testing
(9) High-Tech Imaging (CT/PET/Bone Scan/MRI/MRA/Diagnostic Radiology)
(10) Home Birth
(11) Home Health Care
(12) Home Infusion Therapy (including Nursing Services/Visits, Medication and Other Services)
(13) Hospitalizations (including Inpatient, Inpatient Medical Rehabilitation Facility)
(14) Infertility
(15) Injectable Medications
(16) Inter-facility Transport/Transfer
(17) Intraocular Lens Surgery
(18) Mental Health (including Inpatient Services Facility, Outpatient Services and Partial Hospitalization)
(19) Outpatient Surgical Procedures (excluding Office Based Settings)
(20) Physical, Occupational and Speech Therapies (If visits are limited additional visits require precertification)
(21) Prosthetics and Appliances
(22) Pulmonary Rehabilitation
(23) Radiation Therapy
(24) Skilled Nursing Facility
(25) Temporomandibular Joint Disorder
(26) Transplants (excluding Corneal Transplants)

*Pre-Certification is not required when Medicare is the primary payer. However, any Covered Service not payable by Medicare requires Pre-Certification as indicated above.

The certification process attempts to determine, in advance, the Medical Necessity of the services and the proposed length of stay. A second medical opinion may be used to approve the confinement, if necessary.

Whenever a physician recommends confinement or one of the above services, the Covered Family Member, the physician or an Authorized Representative must contact the Medical Services Team. A toll-free number is on the back of the Covered Family Member's benefit identification card. <u>If a Covered Family Member is admitted because of an Emergency, *the Medical Services Team must be notified within 24 hours*.</u>

A Pre-Service Claim will be reviewed within a reasonable period of time, but no longer than 15 days after receiving the request. The Medical Services Team will notify, in writing, the Covered Family Member or Authorized Representative, the physician, and the Hospital whether or not the Pre-Service Claim has been approved. Requests involving Urgent Care will be reviewed within the time limits described in the section entitled "Determination of Benefits".

Inpatient Maternity Care: Pre-Certification is recommended but is not required for admissions for childbirth. Post-Certification is required in the event an admission for childbirth, including a Hospital stay for the newborn, exceeds 48 hours following a normal delivery or 96 hours following a cesarean section delivery. The Covered Family Member must contact the Medical Services Team within 24 hours or the next business day to certify the additional confinement. The Medical Services Team must be notified within 24 hours of an Emergency admission to a Hospital in connection with pregnancy but not delivery.

Concurrent Stay Review: Concurrent stay review is the process by which the Medical Services Team evaluates the attending physician's request for confinement which continues longer than what was originally Pre-Certified and approved. The Covered Family Member or an Authorized Representative must notify the Medical Services Team of such Concurrent Claim before the Covered Family Member is discharged. A request to Certify a Concurrent Claim will be evaluated within a reasonable period of time, but no longer than 15 days after receiving the request. The Medical Services Team will notify, verbally or in writing, the Covered Family Member or Authorized Representative, the physician, and/or the Hospital whether or not the Concurrent Claim is certified. Requests involving Urgent Care will be reviewed within the time limits described in the section entitled "Determination of Benefits".

Penalty for Non-Compliance: Penalties indicated in the Coverage Summary will apply if a Covered Family Member:

(1) Fails to Pre-Certify one of the services listed, including Emergency admissions, in the subsection entitled "Pre-Certification", or
(2) Remains confined longer than what was initially certified and does not request certification of the Concurrent Claim, or
(3) Fails to request Post-Certification for a maternity stay (including a Hospital stay for the newborn) for a delivery that exceeds 48 hours for a normal delivery or 96 hours for a cesarean delivery or within 48 hours of an Emergency admission not related to delivery.

In order to avoid penalties, the Covered Family Member must call the Medical Services Team for Pre-Certification or certification of a Concurrent Claim.

Utilization Management: The Plan Administrator reserves the right to incorporate a utilization management program into the Plan's benefit provisions. If alternative services are recommended which are not specified in the Plan as Allowable Expenses, the Plan Administrator shall have the right to approve reimbursement of such services. Utilization Management means the systems, strategies, and mechanisms needed to manage appropriate, Medically Necessary and cost-effective health care services.

Utilization Management is intended to:

(1) Assure high quality care and treatment, and
(2) Propose alternative treatments to avoid unnecessary or lengthy confinements and surgeries, and
(3) Promote cost-effective health care, and
(4) Monitor the treatment plan for Covered Family Members with chronic Sickness or catastrophic Injury through medical case management.

When an alternate service involves care at home or is for rehabilitative purposes, the Claim Administrator may provide benefits for the alternate service as an Allowable Expense.

Case Management and Centers of Excellence: In the event of a catastrophic Sickness or Injury, a Covered Family Member may require long-term, perhaps lifetime care. Case Management monitors such patients and explores, discusses and recommends coverage for coordinated and/or alternate types of appropriate Medically Necessary care.

In certain cases, the case manager may recommend coverage of alternative care and/or treatment when Medically Necessary and cost effective at a Center of Excellence, a facility with proven expertise and success rates in the specific type of care and/or treatment needed. If the alternative treatment plan is approved, the Plan Administrator may direct the Plan to cover Medically Necessary expenses as stated in the alternative treatment plan, even if the Plan would not normally pay those expenses.

DETAILED DESCRIPTION OF BENEFITS

If you or your Covered Dependent seek care or treatment from a Network Provider, medical expense benefits will be paid by the Plan according to the Provider Reimbursement Schedule. The Claim Administrator will pay benefits directly to the Provider for Covered Services less any applicable Coinsurance, deductible, or Copayment.

Due to changes that may occur in the participation status of the Provider, it is the responsibility of the Employee to verify that the Provider is still a Participating member.

A list of Network Providers is available from the Medical Claims Administrator listed in the Contact Information section in the front of this document. Network Providers will not balance bill Covered Family Members for covered, authorized services. Out-of-Network Providers may balance bill above negotiated or Allowable Expenses.

Except as specifically set forth below, benefits will not be covered under the Plan when services are received from an Out-of-Network Provider.

If you receive care from a provider who is not a Network Provider, then you may have to submit the claim directly to the Plan.

MEDICAL EXPENSE BENEFITS

This Plan only makes payment decisions based on the benefits provided. It is the responsibility of the patient and the attending physician to decide whether treatment should be rendered regardless if the services are totally or partially Covered, or excluded from coverage under the Plan. The Plan does not and cannot make treatment decisions. The Plan does not select or take any responsibility for the proper or improper performance of any healthcare provided.

Benefits payable under the Plan will be subject to any applicable Coinsurance, Copayments, maximums and deductible amounts, and any limitations as described in the Coverage Summary.

All medical claims **must** be submitted within one year after the claim is incurred **or the claim will be denied.**

The Plan will pay benefits for **Medically Necessary Covered Services** subject to any applicable Coinsurance, Copayments, maximums and deductibles, and any limitations, as shown in the Coverage Summary and elsewhere in this Plan Document. The benefit payment will be based on whether the Covered Family Member receives care from an in-network or out-of-network Provider.

Allowable Expenses are identified by Codes as indicated in the Current Procedural Terminology (CPT) manual developed by the American Medical Association, HCFA-1450 (UB-92), or the Common Procedure Coding System (HCPCS) developed by the Health Care Financing Administration. Covered Medical conditions are identified in the International Classification of Diseases, 10th Revision (ICD-10). Covered Services include:

(1) **Allergy Care**. The Plan covers allergy treatment including, but not limited to, office visits, serum, scratch testing, and laboratory testing. Allergy serum that is Covered under the Prescription Drug Expense Benefit will not be Covered as a Medical Expense Benefit.

(2) **Ambulance and Paramedic Services**. The Plan covers Medically Necessary ambulance or paramedic services in connection with an inpatient confinement or outpatient Emergency treatment to the nearest facility that can provide the necessary care. Air ambulance transportation is Covered if Medically Necessary and if no other mode of transportation is appropriate. Ambulance service used to transport a Covered Family Member from a Hospital or other health care facility or to inpatient confinement at another Hospital or health care facility and home is also Covered when Medically Necessary.

(A) **Ambulance and Paramedic Limitations and Exclusions**: Transport is limited to Medically Necessary transportation by an ambulance. The ambulance must be licensed by the State in which it operates.

(3) **Anesthesia**. The Plan covers anesthesia and its administration.

(4) **Blood, Blood Products and Blood Transfusions**. The Plan covers blood, blood products (including plasma and derivatives) and blood transfusions. The Plan also covers blood donation expenses for Covered Family Members who wish to donate their own blood for their own upcoming surgery or procedure.

Blood, Blood Products and Blood Transfusions Limitations and Exclusions: The Plan does not cover the cost of blood, blood plasma, other blood products, or blood processing or storage charges, when they are available free of charge in the local area, except for blood and blood products required for the treatment of hemophilia when billed by a Hospital or other covered facility.

(5) **Cardiac Rehabilitation**. The Plan covers services for cardiac rehabilitation rendered at a Hospital or freestanding cardiac rehabilitation center. Services must be Medically Necessary due to certain medical conditions, including, but not limited to, post heart transplants, dilated cardiomyopathy, post myocardial infarction, post bypass surgery or angioplasty.

(A) **Cardiac Rehabilitation Exclusions and Limitations**: This benefit is limited to expenses for telemetric monitored exercise for cardiac rehabilitation only. No other exercise programs are Covered. Related testing procedures and physicians' exams will be considered separately. Maintenance cardiac rehabilitation is not Covered.

(6) **Chemotherapy and Radiation Therapy**. The Plan covers chemotherapy and radiation therapy.

(7) **Chiropractic Care**. The Plan covers the services of a chiropractor. Covered Services include the detection and correction, by manual or mechanical means, of misalignment or subluxation of the vertebral column. Therapy performed to stabilize a chronic condition or prevent deterioration is also Covered.

(A) **Chiropractor Limitations and Exclusions**: Maintenance therapy that seeks to prevent disease, promote health, prolong life, and enhance the quality of life is not Covered.

(8) **Convalescent/Skilled Nursing Facility**. The Plan covers inpatient charges if the confinement starts within 30 days of a Hospital stay or 30 days of another Convalescent/Skilled Nursing or Physical Rehabilitation Facility confinement. The previous inpatient Hospital confinement must have been for a minimum of three consecutive days for which inpatient Hospital expense benefits are payable by the Plan. A plan of treatment must be established by the attending physician and must demonstrate the Medical Necessity of the treatment, including the need for continuous care by a physician and 24-hour-a-day skilled nursing care. The physician must be qualified in the state of jurisdiction to prescribe the plan of treatment recommended, must remain available to visit the patient during the admission and provide the patient continuous care. The physician may not have any financial interest in the Convalescent/Skilled Nursing Facility.

(A) The Plan covers the daily charge for room and board that does not exceed the semi-private rate. If the facility does not have a semi-private room available, the Plan will pay the lowest daily rate for the private room and board charge. Outpatient care for physical, occupational, and speech therapy and other services shown in the Coverage Summary is Covered.

(B) **All inpatient admissions to a Convalescent/Skilled Nursing Facility must be Pre-Certified as described in the section entitled "Utilization Management and Medical Review". Failure to Pre-Certify may result in a penalty.**

(9) **Contraceptives**. The Plan covers contraceptive drugs and devices administered by a Provider, including but not limited to: IUDs; contraceptive implants such as Norplant; and contraceptive injections such as Depo-Provera. Such contraceptives are Covered as a service of the Provider who administers them. Contraceptives that are Covered under the Prescription Drug Expense Benefit will not be Covered as a Medical Expense Benefit.

(10) **Diabetic Education**. The Plan covers diabetic self-management education to ensure the Covered Family Member is educated in the proper self-management and treatment of his diabetic condition.

(A) **Diabetic Education Limitations and Exclusions**: Coverage is limited to visits for the diagnosis of diabetes, when a physician diagnoses a significant change in the Covered Family Member's symptoms or conditions which necessitates changes in the Covered Family Member's self-management, or where re-education or refresher education is necessary. Coverage includes home visits when Medically Necessary.

(B) The diabetic education must be provided by a physician or other licensed Health Care Provider, or his staff, as part of an office visit for diabetes diagnosis or treatment, or by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian, upon the referral of a physician or other licensed Health Care Provider.

(11) **Diagnostic Tests**. The Plan covers diagnostic tests performed both inside and outside a Hospital including, but not limited to, diagnostic laboratory services, diagnostic x-rays, diagnostic tests (EKG, EEG, etc.), non-routine mammograms and pap smears, and non-routine prostate specific antigens (PSAs).

(A) All Non-Emergency MRI, MRA and PET scans must be Pre-Certified as described in the section entitled "Utilization Management and Medical Review". **Failure to Pre-Certify may result in a penalty.**

(12) **Dialysis and Hemodialysis**. The Plan covers dialysis and hemodialysis rendered by a licensed technician.

(13) **Durable Medical Equipment, Prosthetics, Braces (Orthotics), Medical Supplies, and Oxygen**. The Plan covers the following services, subject to review of Medical Necessity and the patient's condition:

(A) **Durable Medical Equipment**. The Plan covers rental, or at the Plan's option, purchase of Durable Medical Equipment. The Plan also covers necessary maintenance and repairs of purchased Durable Medical Equipment. Maintenance and repairs can be paid on a per session basis or through an approved maintenance agreement.

(i) All Durable Medical Equipment over $250 must be Pre-Certified as described in the section entitled "Utilization Management and Medical Review". Failure to Pre-Certify may result in a penalty.

(B) **Prosthetic Devices**. The Plan covers the fitting and purchase of prosthetic devices that take the place of a natural internal or external part of a Covered Family Member's body (including, but not limited to, breast prostheses and initial mastectomy bra following a Covered mastectomy) or that are needed due to a congenital or functional defect of a Covered Dependent Child.

(i) Wigs and hairpieces following chemotherapy or radiation therapy are considered Covered prosthetic devices.

(ii) The Plan covers eye exams and contact lenses for aphakic patients and cataract patients who do not receive implants, and soft lenses or sclera shells intended for use in the treatment of Sickness or Injury. Coverage will only be provided when necessitated by damage to the natural eye as a result of an Injury as stated above, or a Sickness which results in similar damage. Services must restore or rehabilitate any resulting loss of vision.

(C) **Braces (Orthotics) and Foot Orthotics**. The Plan will provide benefits for custom made/fitted orthotics (braces), such as a back brace (orthotic) ankle foot orthosis (brace), when prescribed or furnished by a physician, podiatrist, or orthotic specialist. The Plan also covers the fitting and purchase only of custom made braces, foot orthotics, appliances, and orthopedic shoes with appliances that replace a functioning, natural part of the body if determined to be Medically Necessary for the relief or correction of any condition caused by an Injury or Sickness.

(i) **Braces (Orthotics) and Foot Orthotics Limitations and Exclusions:** The Plan does not pay for orthopedic shoes, lifts, supports, and/or other orthopedic devices to be attached to or worn in shoes, unless such devices or their use is determined to be both: (a) an alternative to surgical correction, or is required due to therapeutic processes, and (b) such devices are custom made and designed solely for the individual requiring the orthopedic device.

(ii) Over-the-counter foot orthotics are not Covered under any circumstances, for any condition.

(D) **Medical Supplies**. The Plan only covers Medically Necessary supplies required for the proper functioning of Durable Medical Equipment.

(E) **Diabetic Supplies and Equipment**. Diabetic supplies are Covered as a Prescription Drug Benefit and will not be Covered as a Medical Benefit. Diabetic Durable Medical Equipment is Covered under the Medical Benefit.

(F) **Oxygen**. The Plan covers oxygen and the administration of oxygen. When the Plan covers the purchase of equipment used to administer oxygen, the Plan also covers necessary maintenance and repairs.

(i) **Durable Medical Equipment, Prosthetics, Braces (Orthotics), Medical Supplies, and Oxygen Limitations and Exclusions**: Items used primarily for cosmetic purposes are considered not Medically Necessary. The Plan does

not cover the cost of delivery and set up of deluxe equipment when standard equipment is available and adequate, or the cost of materials used to manufacture equipment.

(ii) Adjustments, maintenance and repairs to Covered devices and medical supplies are Covered if necessary due to normal wear or when required by a change in the patient's condition. Covered Services can be paid on a per session basis or through an approved maintenance agreement, unless Covered by a manufacturer's warranty or purchase agreement. The Plan will also cover Medically Necessary loaner equipment used while repairs are being made.

(iii) The replacement of a Medically Necessary Covered Service is Covered only if:

(iv) The patient has experienced a change in their physiological condition, or

(v) Required repairs would exceed the cost of a replacement device or the parts that need to be replaced, or

(vi) There has been irreparable change in the device's condition or in a part of the device due to normal wear and tear and the device is no longer under warranty.

(14) **Freestanding Surgical Facility**. The Plan covers Medically Necessary treatment rendered in a Freestanding Surgical Facility.

(15) **Genetic Testing.** The Plan covers Genetic Testing, and associated counseling, when Medically Necessary or medically appropriate as determined by the Medical Services Team criteria and peer-reviewed literature. Genetic Testing may be Covered when it is necessary to establish a molecular diagnosis of an inheritable disease when the following criteria are met:

(A) The Covered Family Member has a family or personal history which indicates a significant risk for a genetic defect, and

(B) The result of the test will directly impact the treatment being delivered to the Covered Family Member; and

(C) After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain.

(16) **Home Health Care**. The Plan covers home health care as shown in the Coverage Summary if the plan of treatment is established at the time the physician certifies the Medical Necessity of the home health care services. The plan must be filed with the Claim Administrator. The physician may not have any financial relationship with the Home Health Care Agency furnishing the services. The physician must be qualified under the law of the state to certify the need for home health care and the plan of treatment. It is expected that the physician will see the patient although there is no specified time interval for those visits.

(A) A home health care visit is an episode of personal contact with the patient by the staff of the Home Health Care Agency for the purpose of providing a Covered home health care service. Each time a Home Health Care Agency Employee enters the patient's home to provide a Covered Service to a patient is considered a visit.

(B) Nursing and therapy services authorized as part of a home health care plan and performed by a nurse or therapist affiliated with a Home Health Care Agency are also Covered.

(C) **Home Health Care Limitations and Exclusions**: Charges are not Covered for care and treatment not outlined by the physician in the home health care plan, or home health care incurred during any period when the Covered Family Member is not under the care of a physician.

(17) **Hospice Care**. A Covered Family Member diagnosed with a terminal Illness and a life expectancy of six months or less may receive care by a certified Hospice Care Agency. Hospice care consists of services and supplies, including prescription drugs, provided by the hospice to the extent they are otherwise Covered by this Plan. Treatment may be furnished in a Hospice Facility or Hospital, or on an outpatient basis in the terminally ill Covered Family Member's home under a home care plan provided by a hospice. The Plan covers charges for respite care. Respite care is intended to provide temporary relief to the family or other caregivers during Emergency situations and from the daily demands for caring for the terminally ill Covered Family Member. Inpatient respite care need not meet the normal Medically Necessary criteria for admissions. Hospice care includes bereavement counseling furnished to the family of the terminally ill Family Member by the Hospice Care Agency. Bereavement counseling may be provided before or after the Covered Family Member's death.

(A) **Hospice Care Limitations and Exclusions**: The Plan does not cover:

(B) Charges for a physician employed by the Hospice, or
(C) Any confinement, unless part of respite care, not required for pain control or other acute or chronic system management, or
(D) Services or supplies provided by volunteers or others who do not regularly charge for their services, including pastoral counseling, or
(E) Funeral services or arrangements, or
(F) Legal or financial counseling or services, or
(G) Services, except bereavement counseling, supplied to other Family Members, other than the terminally ill Family Member.
(H) Any expense incurred by a Covered Family Member which is listed in the section entitled "Plan Exclusions".

(I) **All Hospice Care services must be Pre-Certified as described in the section entitled "Utilization Management and Medical Review". Failure to Pre-Certify may result in a penalty.**

(18) **Hospital Services**. The Plan covers inpatient and outpatient treatment in the Hospital:

(A) **Inpatient Hospital Admission**. The Plan covers Hospital miscellaneous expenses. The Plan covers the daily charge for room and board that does not exceed the semi-private rate. If the facility does not have a semi-private room available, the Plan will pay the lowest daily rate for the private room and board charge.

(i) With respect to a confinement related to a dental procedure, the Plan covers Hospital expenses regardless of whether or not the actual dental procedure is Covered. The confinement must be Medically Necessary.

(ii) **All inpatient Hospital admissions, except in connection with childbirth, in which case Post-Certification may be required, must be Pre-Certified as described in the section entitled "Utilization Management and Medical Review". Failure to Pre-Certify may result in a penalty**.

(iii) **Inpatient Hospital Admission Limitations and Exclusions**: The Plan does not cover charges for personal items including, but not limited to, telephone, television and guest trays.

(B) **Outpatient Hospital Treatment**. The Plan covers expenses in the outpatient department of the Hospital. Covered Services include, but are not limited to, outpatient diagnostic testing, chemotherapy, radiation and dialysis.

(i) With respect to outpatient Hospital treatment related to a dental procedure, the Plan covers outpatient Hospital expenses regardless of whether or not the actual dental procedure is Covered. The services must be Medically Necessary.

(C) **Emergency Services**. The Plan covers Medically Necessary Emergency Services for treatment of a medical Emergency in the Emergency room.

(i) Emergency services are services and supplies, including drugs and medicines, for the outpatient emergency treatment of bodily injuries resulting from an accident or a medical condition. Also included is a medical screening examination and ancillary services necessary to evaluate such injury or emergency medical condition and further medical examination and treatment as required to stabilize the patient.
(ii) **Emergency Room Treatment Limitations and Exclusions**: Medical, dental or Behavioral Health related treatment that does not meet the definition of an Emergency, as defined by the Plan, is not Covered.

(19) **Infertility Treatment**. The Plan covers Medically Necessary diagnostic services and treatment of the Sickness or Injury that is the cause of infertility. Treatment must be rendered on an outpatient basis.

(A) **Infertility Treatment Limitations and Exclusions**: The Plan does not cover any service that provides assistance in achieving a pregnancy. The following procedures and similar procedures intended to achieve a pregnancy are excluded from coverage under this Plan's Medical Expense Benefit; artificial insemination, in-vitro fertilization, in-vivo fertilization, gamete inter-fallopian transfer (GIFT), zygote Inter-fallopian transfer (ZIFT) or similar procedures

to achieve a pregnancy. Fertility agents and prescription drug products prescribed to treat infertility are not covered.

(20) **Infusion Therapy**. The Plan covers Medically Necessary treatment by a Covered Provider for infusion of antibiotics, chemotherapy, and other infusion therapies in the Covered Family Member's home or Provider's office. Covered Services include:

(A) Medical care for the patient receiving infusion therapy via central venous line or standard intra-venous route.
(B) Other infusion therapies, including hydration, antibiotics, chemotherapy, pain management, and certain blood products.
(C) Related nursing care and supplies.

Infusion Therapy Exclusion: Notwithstanding the foregoing, the Plan does not cover any type of Gene Therapy. No benefits will be paid for such expenses even if the therapy has received FDA approval. Gene Therapy means therapy that involves replacing a gene that causes a medical problem with one that does not, adding genes to help the body fight or treat disease, or turning off genes that cause medical problems.

(21) **Maternity Care**. The Plan covers charges in connection with prenatal care, delivery and postpartum care, including inpatient routine nursing care. Maternity care includes, but is not limited to, pre and post-natal office visits, associated diagnostic tests, laboratory tests and x-ray charges, semi-private room, general nursing care, Provider services, anesthesia if Medically Necessary, and ancillary services.

(A) The Plan covers Maternity Care for a Dependent Child. The Plan covers complications of a pregnancy for a Dependent Child. The Plan covers an elective abortion (chemically or surgically induced).

(B) *The provisions of the Newborns' and Mothers' Health Protection Act of 1996 provide for a minimum length of stay for the birth of a newborn. Benefits payable under this Plan for a maternity-related Hospital stay must not be restricted for the mother or the newborn to less than 48 hours following a normal delivery or less than 96 hours following a cesarean section unless a shorter stay is agreed to by both the mother and her attending physician*.

(C) **All inpatient Hospital confinements in connection with childbirth in excess of 48 hours following a normal delivery or 96 hours following a cesarean section must be Post-Certified as described in the section entitled "Utilization Management and Medical Review". Failure to Post-Certify such additional confinement in a Hospital may result in a penalty.**

(22) **Mental Illness Treatment**. The Plan covers inpatient confinement for Mental Illness in a Hospital or a Behavioral Health Care Facility. Partial Hospitalization is Covered when Medically Necessary.

(A) The Plan also covers outpatient treatment, including Emergency visits. Outpatient treatment may be furnished in an outpatient department of a Hospital, including the Emergency room, in a Behavioral Health Care Facility, or in a physician's office.

(B) The Plan covers Medically Necessary electro-shock therapy when provided at a Hospital. Associated expenses for a Hospital operating room and the anesthesiologist are Covered.

(C) **All inpatient admissions for the Treatment of Mental Illness must be Pre-Certified as described in the section entitled "Utilization Management and Medical Review". Failure to Pre-Certify may result in a penalty.**

(D) **Mental Illness Treatment Limitations and Exclusions**: Treatment must be directly related to a Mental Illness (as defined). Benefits are not payable for care primarily directed at raising the level of consciousness, social enhancement, retraining, professional training, educational therapy, mental retardation, developmental delays, cognitive training, or counseling limited to everyday problems of living, marriage counseling, situational family counseling, sex therapy, or support groups. Under no circumstances will benefits be provided for therapy that includes the satisfaction of requirements for professional training.

(23) **Newborn Care**. The Plan covers newborn care including nursery charges, charges for routine Provider examinations and tests and charges for routine procedures such as circumcision.

(A) **Pre-Certification is recommended, but not required when the newborn will be a Covered Family Member but the mother will not be Covered. Post-Certification is required when any newborn's Hospital confinement exceeds 48 hours after birth following a normal delivery or 96 hours after birth following a cesarean section.**

(24) **No Network Provider Within 50 Mile Radius.** The Plan does not offer Out-of-Network benefits except for an Emergency as defined in this SPD. However, if there are no Network Providers in the service area (a 50 mile radius of your residential zip code) with appropriate training and experience to meet the particular healthcare needs of the Plan Participant, an Out-of-Network Provider (within the 50 mile radius) may be covered if the services are determined to be Medically Necessary and Pre-Certification has been obtained by the Participant.

(25) **Nutritional Supplements**. The Plan does not cover foods and nutritional/dietary supplements of any kind, including but not limited to [any type of nutritional support even if it is the sole or primary means of adequate nutritional intake that is administered enterally or parenterally;] standardized or specialized infant formula (e.g., Alimentum, Elecare, Neocate, and Nutramigen); lactose-free products or products to aid in lactose digestion, gluten-free food products, high protein or high carbohydrate products and the like; weight-loss or weight-gain foods, formulas or products; normal grocery items, low carbohydrate foods, nutritional supplement puddings, powders, mixes, vitamins and mineral, home meals, formulas, foods, diets, vitamins, herbs and minerals (whether they can be purchased over-the-counter or require a prescription), donor breast milk, baby food, and other non-prescription product/substance that can be mixed in a blender.

(A) Notwithstanding the above, the Plan covers foods and nutritional supplements provided during a covered hospitalization and when prescribed in compliance with Affordable Care Act (ACA) regulations.

(26) **Obesity Treatment**. The Plan covers treatment of clinically severe obesity as defined by the National Heart Lung Blood Institute.

(A) **Outpatient Treatment**. The Plan covers outpatient treatment of obesity if a Covered Family Member has a body mass index (BMI) of greater than 30. Treatment must be rendered according to a written treatment plan. A course of treatment begins and ends as specified in the treatment plan or sooner if the Covered Family Member discontinues treatment. The treatment plan must be approved prior to the services being rendered.

(B) **Surgical Intervention**. Weight loss surgery may be an option for Covered Family Members with clinically severe obesity with a BMI of greater than 40 or a BMI of greater than 35 with an underlying co-morbid condition when other weight loss treatment methods have failed and the Covered Family Member is at high risk for obesity associated Sickness. Surgical intervention must be approved prior to the services being rendered.

(C) **Obesity Treatment Limitations and Exclusions**: The Plan covers one course of treatment, including surgical intervention, per Lifetime per Covered Family Member. Anything not included or not approved in the written treatment plan is not Covered. Appetite suppressants/weight-loss medications are excluded from coverage. Non-prescription appetite or weight control drugs, dietary supplements, special foods or food supplements, health or weight control centers or resorts and health club memberships, subscriptions to books and exercise equipment are not Covered.

(27) **Occupational Therapy**. The Plan covers occupational therapy rendered by a licensed occupational therapist. The therapy must be Medically Necessary as outlined in a plan of treatment by the attending physician and expected to restore bodily functions within a reasonable period of time.

(A) **Occupational Therapy Limitations and Exclusions**: Therapy designed to prevent further deterioration is not Covered.

(28) **Organ and Bone Marrow Transplants**. The Plan covers Medically Necessary organ and bone marrow transplants; including Medically Necessary stem cell transplants, that are not considered Experimental or Investigative.

(A) The Plan will cover the expenses of the donor who is not a Covered Family Member under this Plan provided there is no other coverage available. If other coverage is available to the donor, this Plan will be the secondary payer.

(B) If the donor is Covered under this Plan, the donor's Covered expenses will consist of medical expenses incurred to donate the organ or bone marrow but only to the extent that such expenses are not Covered by the intended recipient's plan. In this case, this Plan is secondary to any coverage of the intended recipient's plan.

(C) The following conditions must apply to such procedures:

(D) The procedure must be performed at a facility known for having an effective program for doing such procedures, and

(E) The Covered Family Member must be a likely candidate for the successful outcome of such a procedure, and

(F) Medical expenses for the donor and the recipient must be considered Allowable Expenses under this Plan.

(G) Benefits are payable for the following:

(H) The cost of registering the Covered Family Member recipient with a transplant registry.

(I) Pre-transplant services provided to donors in anticipation of a transplant. Covered Services include laboratory tests (including tissue typing), and general medical evaluations.

(J) Acquisition services for an organ or bone marrow from a living donor or from a cadaver. Organ transplant expenses to include transportation of the organ to the place of transplantation, including the cost of a technician, packing and preservation, and injections of antibodies, but not charges for lodging or meals of a courier, or finder's fees.

(K) Charges for transportation of the recipient from one facility to another facility where the procedure will be performed.

(L) Routine post-operative care for both the recipient and donor as well as for complications that result from the procedure.

(M) **Organ and Bone Marrow Transplants Limitations and Exclusions**: The Plan does not cover:

(N) Legal fees, finder fees, and any other fee paid to or on behalf of the donor for the organ or bone marrow.

(O) Charges incurred for mechanical devices designed to replace human organs (except for charges for a kidney dialysis machine or use of a mechanical heart to keep a patient alive until a human heart donor becomes available).

(P) Charges incurred for keeping a donor alive for transplant purposes.

(Q) Travel expenses (including meals and lodging) incurred by a live donor, travel companion or the recipient incurred to any transplant center.

(R) **All services in connection with Organ and Bone Marrow Transplants must be Pre-Certified as described in the section entitled "Utilization Management and Medical Review". Failure to Pre-Certify may result in a penalty.**

(29) **Participation in Clinical Trials**. The Plan covers routine costs (i.e., standard of care) of approved clinical trials. Routine costs include:

(A) Items and/or services that would be provided if there were no clinical trial (e.g., conventional care such as hospital services, room and board, physician services, office visits, laboratory and diagnostic tests);

(B) Items and/or services required to administer the item or service being investigated (e.g., administration of a chemotherapy drug being tested),

(C) Clinical monitoring of the effects of the item and/or service being investigated;

(D) The prevention of complications; and

(E) Other reasonable and necessary items and/or services arising from the trial (e.g., the diagnosis or treatment of complications).

(F) **Participation in Clinical Trials Limitations and Exclusions**: Non-routine costs include, but are not limited to, the following and are not Covered under the Plan:

(G) The item, treatment, drug and/or service being investigated;

(H) Items and/or services provided only to satisfy the collection and analysis of data for the trial, that are not used in the direct clinical management of the patient (e.g., monthly CT scans when only a single scan would be Medically Necessary, transportation to and from the study site);

(I) Items and/or services provided by the research sponsors free of charge; and

(J) Duplicative services.

(30) **Physical Rehabilitation Facility**. The Plan covers charges by a Physical Rehabilitation Facility. The Plan covers inpatient charges if the confinement starts within 30 days of a Hospital stay or 30 days of another Physical Rehabilitation Facility or Convalescent/Skilled Nursing Facility confinement. The previous inpatient Hospital confinement must have been for a minimum of three consecutive days for which inpatient Hospital expense benefits are payable by the Plan. A plan of treatment must be established by the attending physician at the time rehabilitation service is provided and must demonstrate the Medical Necessity of the treatment, including the need for continuous care of a physician and 24-hour-a-day nursing skilled care. The physician must be qualified in the state of jurisdiction to prescribe the plan of treatment recommended, must remain available to visit the patient during the admission and provide the patient continuous care. The physician may not have any financial interest in the Physical Rehabilitation Facility.

(A) The Plan covers the daily charge for room and board that does not exceed the semi-private rate. If the facility does not have a semi-private room available, the Plan will pay the lowest daily rate for the private room and board charge. Outpatient care for physical, occupational, and speech therapy and other services shown in the Coverage Summary are Covered.

(B) **All inpatient admissions to a Physical Rehabilitation Facility must be Pre-Certified as described in the section entitled "Utilization Management and Medical Review". Failure to Pre-Certify may result in a penalty.**

(31) **Physical Therapy**. The Plan covers physical therapy rendered by a licensed physical therapist. The therapy must be Medically Necessary as outlined in a plan of treatment by the attending physician and expected to restore bodily function within a reasonable period of time.

(A) **Physical Therapy Limitations and Exclusions**: Therapy designed to prevent further deterioration is not Covered.

(32) **Physician and Health Care Providers**. The Plan covers:

(A) **Office and Inpatient Visits**. The Plan covers non-surgical office and inpatient visit charges by a physician or other Provider for treatment of a Sickness or Injury. Inpatient or outpatient Provider visits and office consultations by a specialist are also Covered.

(i) The Medical Expense Benefit portion of the Plan will cover the associated administration or insertion of the Covered prescription medication or device. Prescription drugs dispensed but not administered in the physician's office are not Covered.

(B) **Surgery**. The Plan covers Medically Necessary surgery, co-surgery, assistant surgery, and Reconstructive Surgery.

(i) Surgery (including multiple surgery or multiple surgical procedures) is defined by the American Medical Association's Current Procedural Terminology (CPT) and by the Healthcare Common Procedure Coding System (HCPCS). All surgical procedures, including multiple surgical procedures, are subject to clinical edits and must fall within standards of practice as defined by the American Medical Association, are subject to review for Medical Necessity, and approval by the appropriate governmental agency. Surgery will include physical complications in all stages of Covered surgeries including, but not limited to, mastectomies and lymphedema.

(C) **Second Surgical Opinion**. The Plan covers charges for a second surgical opinion including associated x-rays and tests. This Plan also covers charges for a third opinion, including associated x-rays and tests if necessary, if the second opinion differs from the first.

(i) Second opinions, (and third opinions when necessary), must be rendered by physicians who are board certified, and qualified by reason of their specialty, to give an opinion on the proposed surgery or Hospital admission. The physician must not be a Business Associate of the physician who recommended surgery or the Hospital admission.

(D) **Second Medical Opinion**. The Plan covers charges for a second medical opinion by an appropriate specialist for a positive or negative diagnosis of cancer, a recurrence of cancer, or a recommendation of a course of treatment for cancer.

(E) **Treatment of an Injury to Teeth**. The Medical Plan also covers treatment of an Injury to sound, natural teeth. The Injury must not be caused, directly or indirectly, by biting or chewing and all treatment must be complete within 12 months of the date of the Injury. Treatment includes replacing natural teeth lost due to such Injury. A sound natural tooth is any tooth that has adequate bone structure, healthy periodontium, and healthy support tissue. A tooth may have been restored in any manner including fillings or a crown but will still be considered a sound and natural tooth as long as the "support" of the tooth remains intact. The above dental services will be Covered if they can be identified in the Current Dental Terminology (CDT) developed by the American Dental Association.

(i) **Limitations and Exclusions**: The Medical Plan does not cover any service or care for treatment of the teeth, gums, or structures supporting the teeth; or any form of dental surgery; regardless of the reason, except as described above. Refer to the Section entitled "Dental Benefits" section for coverage information.

(F) **Temporomandibular Joint Dysfunction (TMJ)**. The Plan covers treatment for degenerative arthritis, traumatic arthritis, ankylosis, temporomandibular joint dysfunction or other organic pathology of the joint when the diagnosis can be substantiated by positive radiographic findings. Covered Services include the examinations, diagnosis, consultations, x-rays, radiographs and laboratory tests, injections of muscle relaxants, local anesthesia or steroids, transcutaneous electrical nerve stimulation (TENS), electro-galvanic nerve stimulation (EGS), and physical therapy.

(33) **Podiatrist**. The Plan covers charges by a podiatrist for treatment of an Injury, Sickness, or deformity of the feet.

(34) **Preadmission Testing**. The Plan covers preadmission testing prior to surgery. Tests must be performed in association with a planned admission and must be accepted by the Hospital in place of the same post-admission tests. Tests repeated after admission or before surgery are not Covered, unless the admission or surgery is deferred solely due to a change in the health of the Covered Family Member.

(35) **Prescription Drugs.** The Plan covers medically necessary prescription drug expenses under the section entitled "Prescription Drug Expense Benefit" not otherwise excluded in this Plan.

The Medical Expense Benefit portion of the Plan covers the associated administration or insertion of the covered prescription medication or covered device.

Prescription Drugs Limitations and Exclusions: Prescription drugs dispensed but not administered in the physician's office are not covered.

(36) **Preventative Care and Well Care**. The Plan covers preventive and well care based on the guidelines provided by the Patient Protection and Affordable Care Act:

(A) **Preventative Care for a Child**. The Plan covers routine preventative/well-care visits up to age 19 for a Dependent Child.

(i) This benefit covers well-baby and well-child care which consists of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. Also covered are preventive care and screenings as provided for in the comprehensive guidelines supported by Health Resources and Services Administration ("HRSA") and items or services with an "A" or "B" rating from the US Preventative Services Task Force (USPSTF). Immunizations and boosters as required by Advisory Committee on Immunization Practices (ACIP) are also covered.

(B) **Preventative Care for an Adult**. The Plan covers routine preventative care for an adult Covered Family Member. The Plan follows the national guidelines of the USPSTF and ACIP. Such care includes medical testing, routine physical exams including related laboratory tests, x-rays, and appropriate immunization and vaccines.

(C) **Routine Pap Smears and Pelvic Exams**. The Plan covers charges for routine pap smears and pelvic exams as recommended by the attending physician and that are accepted medical practice.

(D) **Routine Mammography Screening**. The Plan covers charges for routine mammography screenings

(i) Upon the recommendation of a Provider, at any age if a Covered Family Member has a prior history of breast cancer or whose mother, sister or daughter has a prior history of breast cancer or is otherwise at risk; or

(ii) A single baseline mammogram for Covered Family Members age 35 to 39 years of age; or

(iii) An annual mammogram for Covered Family Members age 40 or older.

(E) **Prostate Cancer Screening**. The Plan covers routine prostate cancer screening, including an annual digital rectal examination and a prostate specific antigen test for men age 50, or over who are not symptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors.

(F) **Colon Cancer Screening**. The Plan covers a routine screening colonoscopy for Covered Family Members beginning age 50 and continuing until age 75 years and as considered appropriate under the USPSTF guidelines. .

(G) **Family Planning**. The Plan covers Allowable Expenses related to family planning including: voluntary sterilization of males and females. The reversal of a voluntary sterilization is not Covered. The Medical Expense Benefit portion of the Plan covers contraceptive devices, such as intrauterine devices (IUDs), and the associated cost of insertion. Elective abortions are also Covered.

(H) **Routine Vision Exam**. The Plan covers a routine vision exam up to the limits described in the Coverage Summary.

(I) **Routine Hearing Exam**. The Plan covers a routine hearing exam up to the limits described in the Coverage Summary.

(J) **Bone Density Testing**. The Plan covers bone mineral density measurements and tests for the detection of osteoporosis if medically appropriate and recommended by the attending physician.

(K) **Women's Preventive Care**. The Plan covers women's preventive care as described by the Health Resources and Services Administration (HRSA) which includes, but is not limited to, well-woman visits, screening for gestational diabetes, contraceptive methods and counseling, and breastfeeding support, supplies, and counseling.

(37) **Respiratory Therapy**. The Plan covers respiratory therapy rendered by a licensed respiratory therapist.

(38) **Speech Therapy**. The Plan covers speech therapy rendered by a licensed speech therapist when needed by a Covered Family Member due to Sickness or Injury. Speech therapy must be performed to restore speech that was lost due to a Sickness or Injury. The treatment must also be active treatment for a medical condition resulting in functional defect or be for the correction of a speech impairment resulting from said Sickness or Injury, including previous therapeutic processes. The therapy must also be Medically Necessary as outlined in a treatment plan by the attending physician and expected to restore bodily function within a reasonable period of time.

(A) **Speech Therapy Limitations and Exclusions**: This Plan does not cover speech therapy services that are educational in any part, or due to articulation disorders, tongue thrust, stuttering, lisping, abnormal speech development, changing an accent, dyslexia, hearing loss which is not medically documented or similar disorders. Therapy designed to prevent further deterioration is not Covered.

(39) **Substance Abuse Treatment**. The Plan covers inpatient confinement for Substance Abuse in a Hospital or Behavioral Health Care Facility. Partial Hospitalization is Covered when Medically Necessary.

(A) The Plan also covers outpatient treatment, including Emergency visits. Twenty of these visits may be used for family counseling.

(B) **All inpatient admissions for the Treatment of Substance Abuse must be Pre-Certified as described in the section entitled "Utilization Management and Medical Review". Failure to Pre-Certify may result in a penalty.**

(40) **Urgent Care Facility**. The Plan will pay for Covered Services rendered in an Urgent Care Facility.

(41) **Vision Benefit**. For each Participant, Spouse and Dependent, the Plan pays the cost of an eye examination every calendar year performed by a legally qualified optometrist, ophthalmologist or optician.

PRESCRIPTION DRUG EXPENSE BENEFIT

The Prescription Drug Benefit is administered by Pharmacy Benefit Dimensions (PBD) and follows the PBD five (5) tier formulary.

Covered Prescription Drugs

The Plan covers Medically Necessary Prescription Drugs that can be dispenses only pursuant to a prescription and:

(1) Are not excluded elsewhere in this Plan;
(2) Are required by law to bear the legend "Caution – Federal Law prohibits dispensing without a prescription";
(3) Are FDA approved;
(4) Are ordered by a Provider authorized to prescribe and within the Provider's scope of practice;
(5) Are prescribed within the approved FDA administration and dosing guidelines;
(6) Are dispensed by a network licensed pharmacy;
(7) Follow the five (5) tier formulary of PBD

Formulary

(1) See PBD brochure and Formulary attached to this SPD for additional information.
(2) The information contain in the PBD 5 tier formulary applies to all members enrolled in this Plan.
(3) If you require and additional copy of the Formulary contact PBD at the number listed on your ID Card or on their website (https://www.pbdrx.com/).
(4) PBD reserves the right to modify drug tiers at any time.

For More Information: If you have a question about a covered prescription or supply, or for more information about a specific drug or service described above, contact the Claims Administrator at the number listed on the back of your ID card.

Medicare Part D Creditable Coverage: If you are Medicare-eligible, you should be aware that Medicare offers prescription drug coverage (known as Medicare Part D). You are not required to choose this coverage. The Plan will continue to provide your prescription drug coverage if you become Eligible for Medicare. If you enroll in coverage under this Plan and under Medicare Part D, you will be paying more for additional insurance that you may not need as Medicare Part D will not supplement your coverage under this Plan. There is no coordination between the plans.

Prescription drug coverage under this Plan is, on average, at least as good as Medicare prescription drug coverage; therefore, there is no advantage to signing up for Medicare Part D coverage. The government refers to this as "creditable coverage". Since the Plan's coverage is considered to be creditable, you will not be subject to penalties or restrictions if you later choose to enroll in a Medicare prescription drug plan.

DENTAL BENEFITS

Dental Benefits are provided on a self-insured basis through the Fund under a program administered by the Dental Claims Administrator listed in the Contact Information section in the front of this SPD.

Dental Benefits are subject to the Exclusions and other provisions of this SPD unless otherwise described in this section. Employees may opt out of this benefit at any time.

Choice of Dentists: For the purposes of this section only, members may receive services from a Network or Out-of-Network Provider.

Under the Dental Plan, you have the option to receive dental services from either a Network Provider or from an Out-of-Network. If

you or your Covered Family Members seek care or treatment from a Network Provider or from an Out-of-Network Provider, dental benefits will be paid by the Plan according to the Network Provider Reimbursement Schedule.

A list of Network Providers can be obtained through the Dental Claims Administrator listed in the Contact Information in this SPD.

Dental Expense Benefits: This Plan only makes payment decisions based on the benefits provided. It is the responsibility of the patient and the attending dentist to decide whether treatment should be rendered regardless if the services are totally or partially Covered, or excluded from coverage under the Plan. The Plan does not and cannot make treatment decisions. The Plan does not select or take any responsibility for the proper or improper performance of the care provided.

Benefits payable under the Plan will be subject to any applicable Coinsurance, Copayments, maximums and deductible amounts, and any limitations as described in the Coverage Summary.

All dental claims **must** be submitted within one year after the claim is incurred **or the claim will be denied.**

Dental Plan Exclusions: The Dental Benefit excludes the following services in addition to those outlined under Plan Exclusions beginning in the section titled Plan Exclusions.

(1) Space Maintainers
(2) Gold Fillings
(3) Orthodontia
(4) Treatment of TMJ
(5) Bleaching

Payment Schedule: For services incurred for the Covered benefits listed in the Coverage Summary, the plan will pay the following percentages of the PPO fee schedule allowance or the billed charge, whichever is less.

Covered Service	Network	Out-Of-Network
Preventive Services	100% of Fee Schedule Allowance	100% of Fee Schedule Allowance
Basic Services	65% of Fee Schedule Allowance	65% of Fee Schedule Allowance
Major Services	40% of Fee Schedule Allowance	40% of Fee Schedule Allowance

It is important to note that if you receive services from an Out-of-Network Provider the allowed percentage of the Network Provider Negotiated rate will be paid. If the fee for the Out-of-Network Provider is more than the negotiated rate, the provider may balance bill you for charges above the fee schedule amount less the payment made by the plan. Most times, there is a significant cost savings to the member when utilizing an Network dentist. See Examples below:

Example 1
Member A receives Covered Preventive Services from an Network dentist.
Billed claim submitted = $150
Fee Schedule Allowance = $100
Plan pays 100% of Fee Schedule allowance for preventive services = $100
Member A pays $0
Member B receives Covered preventive services for an out-of-network dentist
Billed claims submitted = $150
Fee Schedule Allowance = $100
Plan pays 100% of Fee Schedule allowance for preventive services = $100
Member B pays the difference between the billed charge of $150 and the fee schedule
Allowance of $100
Member B pays $50
Member A paid $50 less than Member B by using an Network Provider

Example 2
Member A receives a Basic Service from an Network Provider
Billed claim submitted = $300.00
Fee Schedule Allowance = $225.00
Plan pays 65% of Fee Schedule Allowance for Basic Services = $146.25

Member A pays $78.75 ($225.00 - $146.25)
Member B receives a Basic Service from an Network Provider
Fee Schedule Allowance = $225.00
Member B pays $153.75 ($300.00 - $146.25)
Member A paid $75.00 less than Member B by utilizing an Network Provider

PLAN EXCLUSIONS

The following general exclusions apply to all sections of this Plan. Specific Limitations and Exclusions for individual Plan benefits are indicated in the Coverage Summary or with that benefit in the Detailed Description of Benefits.

(1) **Acupuncture.** The Plan does not cover acupuncture.

(2) **Alternative Service.** The Plan will not provide benefits for alternative or complementary health services, products, remedies, treatment and therapies including, but not limited to, hypnosis, and hypnotherapy, naturopathy, homeopathy, primal therapy, carbon dioxide therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, aromatherapy, hair analysis, thermograms and thermography, yoga, meditation, and recreational therapy and any related diagnostic testing.

(3) **Any Other Employment.** The Plan does not cover any Sickness, Injury, occupational disease or condition arising out of, or in the course of, any employment for wage, profit, intent of profit, or self-employment, or for which the Covered Family Member is or was entitled to receive workers' compensation benefits.

(A) This also includes any Sickness or Injury arising out of the business pursuits of a Covered Family Member in connection with a business owned or financially controlled by the Covered Family Member or by a partnership, corporation or other working arrangement of which the Covered Family Member is a partner or member. A business pursuit is a continuous or regular activity engaged in by the Covered Family Member for the purpose of earning a profit, whether or not the business is profitable or a livelihood. The business pursuit exclusion is intended to apply to any activities that are involved with one's business, employment, trade, occupation, or profession.

(B) This exclusion applies even if the Covered Family Member's right to workers' compensation has been waived, qualified, or not asserted.

(3) **Automobile Insurance.** The Plan does not cover charges for which the Covered Family Member is Eligible to receive benefits through mandatory no fault, fault automobile, or tort insurance, an uninsured motorist insurance law, or any other motor vehicle liability insurance policy, including under-insured individuals. The Claim Administrator will take into consideration any adjustment option chosen under such part by the Covered Family Member. If a Covered Family Member is ineligible to receive benefits through mandatory no-fault insurance or uninsured motorist insurance law due to his operation of a motor vehicle while he is intoxicated (DWI), while his ability is impaired (DWAI), or while under the influence (DUI) as defined by applicable state law, or other diagnostic tests indicating the impermissible presence of drugs or alcohol, regardless of whether or not charges are filed, no payment will be made under this plan for charges incurred by that Covered Family Member in connection with the resulting Injury.

(A) This exclusion applies even if the Covered Family Member fails to make a proper or timely claim for benefits available under the motor vehicle insurance policy or applicable law.

(4) **Biofeedback**. The Plan does not cover biofeedback.

(5) **Blood, Blood Products and Blood Transfusions Limitations and Exclusions**. The Plan does not cover the cost of blood, blood plasma, other blood products, or blood processing or storage charges, when they are available free of charge in the local area, except for blood and blood products required for the treatment of hemophilia when billed by a Hospital or other covered facility.

(6) **Civil and Criminal Misconduct.** The Plan does not cover any service or care related to the treatment, Sickness, or Injury arising out of a Covered Family Members participation in a felony. The felony will be determined by the law of the State where the criminal behavior occurred.

(7) **Cloning.** The Plan does not cover expenses related to cloning.

(8) **Clothing.** The Plan does not cover charges for special clothing, except for Medically Necessary burn garments, lymphedema garments, or mastectomy bras.

(9) **Communication Devices**. The Plan will not provide benefits for the purchase, rental, repair, replacement or maintenance of devices for speaking, listening, or otherwise communicating, including, but not limited to telecommunication devices for the deaf (TDDs) and teletype machines (TTYs) , or for services for evaluation, fitting , or modification of such devices.

(10) **Cosmetic Procedures.** The Plan does not cover cosmetic surgery or procedures, unless it qualifies as Reconstructive Surgery as defined, including human or artificial hair transplants or any drug, prescription or otherwise, used to eliminate baldness. Medications used for cosmetic purposes are excluded from coverage.

(11) **Court Mandated Services.** The Plan does not cover charges related to court mandated non-Medically Necessary services for therapy or treatment for Mental Illness, Substance Abuse or any other health services. The Plan will retain the right to cover such services if they are deemed to be Medically Necessary.

(12) **Custodial Care.** The Plan does not cover charges for or in connection with Custodial Care (except as specifically Covered in the Plan) sanitariums, rest care, or nursing homes.

(13) **Dental Implants.** The Medical Plan does not cover charges for or in connection with dental implants. Refer to Dental Benefits for coverage information.

(14) **Disallowed Benefits or Penalties.** The Plan does not cover charges for penalties or disallowed benefits determined by a primary health plan as determined in the section entitled “Coordination Of Benefits”, Medicare, an HMO or other managed care plan due to failure of the Covered person to obtain the proper Pre-Certification, second opinion, or any other reason including failure to comply with the requirements of the primary care physician network established by the HMO or managed care plan or by voluntarily obtaining services outside the established provider network thereby incurring a reduction or denial of benefits. For any penalty imposed due to failure to adhere to the conditions of the section entitled “Utilization Management and Medical Review”.

(15) **Educational and Recreational Therapy.** The Plan does not cover charges for recreational or educational therapy, forms of self-care or self-help training, or marital, family or other counseling or training services unless specifically Covered elsewhere under the Plan.

(16) **Experimental or Investigative.** The Plan does not cover any and all charges resulting from Experimental or Investigative procedures as defined in the Plan, including, but not limited to, all Experimental organ transplants and Experimental organ implants. For Experimental or Investigative drugs or substances not approved by the Food and Drug Administration or for drugs labeled "Caution - limited by Federal Law to investigational use," including any drug or substance which is Experimental or Investigative.

(17) **Eyewear.** The Medical Expense Benefits portion of the Plan will not cover frames, corrective lenses or any other service related to routine corrective lenses.

(18) **Family Planning.** The Plan does not cover expenses related to a reversal of a sterilization operation, artificial insemination, in vitro fertilization, sperm washing, and for a surrogate mother. However, the expenses for the birth of a Child as the result of artificial insemination, in vitro fertilization, or other methods of conception, will be Covered and the expenses of the Child of a surrogate mother if the Child has been placed for adoption with the Covered Employee. "Placed" means the assumption and retention of fora legal obligation for total or partial support of a Child in anticipation of adoption of such Child.

(19) **Foot Care.** The Plan does not cover for routine or palliative foot care such as treatment of corns, calluses, toenails, flat feet, fallen arches, chronic foot strain, reduction of nails, or symptomatic complaints of the feet, except if necessitated due to metabolic conditions such as diabetes.

(20) **Foreign Medical Care.** The Plan does not cover charges incurred by a Covered Family Member for drugs, procedures, services, supplies or treatment rendered or received in person, by mail or otherwise outside the United States if the purpose of such travel or communication is to obtain or receive such drugs, procedures, services, supplies or treatment.

(21) **Gene Therapy.** The Plan does not cover charges for any type of Gene Therapy. No benefits will be paid for such expenses even if the therapy has received FDA approval. Gene Therapy means therapy that involves replacing a gene that causes a medical problem with one that does not, adding genes to help the body fight or treat disease, or turning off genes that cause medical problems.

(22) **Government Hospitals (VA Hospitals).** The Plan does not cover services or supplies furnished to the Covered Family Member in a Hospital owned or operated by the United States Government or any other government or in a facility maintained by the Veteran's Administration unless there is a legal obligation to pay such charges without regard to the existence of any coverage.

(23) **Hazardous Hobbies for Cash or Prize Money.** The Plan does not cover charges incurred for the treatment of a Sickness or Injury that is the result of engaging in a hazardous hobby for cash compensation or prize money. A hobby is considered hazardous if it is an unusual activity characterized by a constant threat of danger or risk of bodily harm. Examples of hazardous hobbies include but are not limited to automobile, bicycle and motorcycle racing, skydiving, hang gliding, ATV operation, jet skiing, snowmobiling, skateboarding, or bungee jumping.

(24) **Herbal and Homeopathic Remedies.** The Plan does not cover charges for herbal and homeopathic remedies.

(25) **Ineligibility.** The Plan does not cover charges that are incurred before a participant becomes Covered by the Plan, after the Covered Family Member's coverage ended, or after the Plan has terminated.

(26) **Infertility Treatment Limitations and Exclusions**. The Plan does not cover any service that provides assistance in achieving a pregnancy. The following procedures and similar procedures intended to achieve a pregnancy are excluded from coverage under this Plan's Medical Expense Benefit; artificial insemination, in-vitro fertilization, in-vivo fertilization, gamete inter-fallopian transfer (GIFT), zygote Inter-fallopian transfer (ZIFT) or similar procedures to achieve a pregnancy. Fertility agents and prescription drug products prescribed to treat infertility are not covered.

(27) **Interns and Residents.** The Plan does not cover services rendered and billed by a resident physician or intern while serving in that capacity.

(28) **Late Filed Claims.** The Plan does not cover bills submitted to the Plan after the timely filing limitation as described in section entitled "Timely Claim Filing Requirement".

(29) **Licensing and Certification Restrictions.** The Plan does not cover charges for care, services, or supplies rendered which are not within the scope of the professional license of the person providing them.

(30) **Massage Therapy.** The Plan does not cover massage therapy.

(31) **Medical Equipment and Supplies.** The Plan does not cover any charge for equipment that does not meet the definition of Durable Medical Equipment, including but not limited to: air conditioners, humidifiers, exercise equipment, etc.

(32) **Medicare.** The Plan does not cover charges to the extent that the Covered Family Member is reimbursed, entitled to reimbursement, or in any way indemnified for those expenses by Medicare. (This exclusion will not apply if this Plan is obligated by law to pay its benefits before Medicare.) Any individual who, at any time, was entitled to enroll in all or any portion of the Medicare program but who did not so enroll, will be considered to be entitled to reimbursement in an amount equal to the amount to which he would have been entitled, if any, if he were so enrolled.

(33) **Non-Emergency Services.** The Plan does not provide benefits for Emergency services rendered for a non-Emergency medical condition (as defined by the Plan).

(34) **Non-Recognized Provider**. The Plan does not cover any services or supplies provided by an individual who does not meet the Plan definition of Provider or Health Care Provider.

(35) **Not Legally Required to Pay.** The Plan does not cover charges which would not have been made if no coverage had existed or for which the Covered Family Member is not legally required to pay, or payment is unlawful in the jurisdiction where the person resides at the time expenses are incurred.

(36) **Not Medically Necessary.** The Plan does not cover charges that are not Medically Necessary, as defined, except as specifically provided for in this Plan.

(B) The fact that a physician may prescribe, order, recommend or approve a procedure, treatment, facility, supply, device, or drug does not, in and of itself, make it "Medically Necessary" or make the charge a Covered Service under the Plan, even if it has not been listed as an exclusion. All of the facts and circumstances surrounding the claim must be considered.

(37) **Non-Human Organ/Tissue Transplants or Zenographs.** The Plan does not pay for any services relating to Non-Human organ/tissue transplants or zenographs.

(38) **Nutritional Counseling.** The Plan does not cover nutritional counseling.

(39) **Nutritional/Dietary Supplements.** The Plan does not cover foods and nutritional/dietary supplements of any kind, including but not limited to [any type of nutritional support even if it is the sole or primary means of adequate nutritional intake that is administered enterally or parenterally;] standardized or specialized infant formula (e.g., Alimentum, Elecare, Neocate, and Nutramigen); lactose-free products or products to aid in lactose digestion, gluten-free food products, high protein or high carbohydrate products and the like; weight-loss or weight-gain foods, formulas or products; normal grocery items, low carbohydrate foods, nutritional supplement puddings, powders, mixes, vitamins and mineral, home meals, formulas, foods, diets, vitamins, herbs and minerals (whether they can be purchased over-the-counter or require a prescription), donor breast milk, baby food, and other non-prescription product/substance that can be mixed in a blender.

(B) Notwithstanding the above, the Plan covers foods and nutritional supplements provided during a covered hospitalization and when prescribed in compliance with Affordable Care Act (ACA) regulations.

(40) **Obesity Treatment/Weight Reduction.** The Plan does not cover charges for diet programs (Weight Watchers, Nutrisystem, etc.), prescription weight loss drugs or diet supplements.

(41) **Other Party Liability.** The Plan does not cover charges with respect to any Sickness or Injury for which any party other than the Plan may be legally responsible or liable unless the Covered Family Member fully complies with the section entitled "Subrogation/Reimbursement Provision".

(42) **Out-of-Network. T**he Plan will no longer offer Out-of-Network benefits except for an Emergency, No Control or No Network Provider within 50 Mile Radius situations as defined in your SPD.

(43) **Over-the-Counter Medical Drugs and Medical Supplies.** The Plan does not cover any items that can be obtained without a prescription, except as otherwise allowed in the Plan.

(44) **Patient Charges and Penalties.** The Plan does not cover charges for telephone consultations, charges for failure to keep a scheduled visit, or charges for the completion of claim forms, new patient processing, and late payment, penalty or interest charges caused by the patient's action or inaction.

(45) **Physical Exams.** The Plan does not cover routine exams and immunizations for the sole purpose of employment, school, camp, or travel to a foreign country or extracurricular activities.

(46) **Prescription Drugs.** Prescription drugs dispensed but not administered in the physician's office are not covered.

(47) **Private Duty Nursing.** The Plan does not cover private duty nursing.

(48) **Prohibited Referral.** The Plan will not provide coverage for any pharmacy, clinical laboratory, radiation therapy, physical therapy, x-ray, or imaging services that were provided pursuant to a referral prohibited by the New York Public Health Law.

(49) **Public or Government Program Reimbursements.** The Plan does not cover charges to the extent that the Covered Family Member is reimbursed, entitled to reimbursement, or in any way indemnified for those expenses by or through any public or government

program or applicable law, other than the program of Medical Assistance for Needy Persons (Medicaid).

(50) **Room and Board.** The Plan does not cover charges incurred for room and board for a Covered Family Member in any Hospital or facility for any period of time during which that individual was not physically present.

(51) **Refractive Eye Surgery.** The Plan does not cover eye surgery for the correction of visual acuity, including, but not limited to, LASIK and radial keratotomy.

(52) **Routine Physical Examinations/Services.** The Plan does not cover routine exams and services rendered in a Hospital during an inpatient confinement (except charges for routine nursery care of newborn Child), unless otherwise specified in the Plan.

(53) **Self-Inflicted Injury.** The Plan does not cover any intentionally self-inflicted Sickness or Injury, except for treatment resulting from a medical condition (including behavioral health disorders).

(54) **Services of a Relative or Household Member.** The Plan does not cover services provided by your immediate family (the patient's Spouse, children, brother, sisters, parent of Spouse or other person residing with the patient).

(55) **Sex Reassignment Surgery and Related Services.** The Plan does not cover hormone therapy, sexual reassignment surgery, counseling for transsexuals, and related charges to alter the physical characteristics of your biologically determined gender to those of another gender.

(56) **Training.** The Plan does not cover expenses incurred for education or training (except as specifically Covered in the Plan) including training for dyslexia and similar procedures, perceptual training and learning disability training.

(57) **Transportation.** The Plan does not cover charges incurred for travel, other than transportation via Medically Necessary ambulance, or as otherwise specified in the Plan.

(58) **Vision Therapy.** The Plan does not cover vision therapy or training for dyslexia and similar procedures, perceptual training and learning disability training. However, the Plan covers vision therapy when Medically Necessary for certain conditions including, but not limited to, amblyopia, esotropia, and convergence insufficiency.

(59) **War.** The Plan does not cover expenses resulting from, or in connection with, any Sickness or Injury resulting from war or any act of war, whether or not declared, or any Sickness or Injury sustained while in any of the Armed Forces of any country or international authority, or sustained while engaged in any armed conflict.

OTHER PLAN BENEFITS

LIFE INSURANCE BENEFIT

Benefit: If you are Enrolled for Employee medical coverage or have filed an active Waiver under the Plan upon eligibility, on the form provided by the Fund Office, you will be entitled to a life insurance benefit in an amount of Thirty Thousand Dollars ($30,000). This benefit is provided to you by the Fund through an insurance contract. This contract shall control, for the purposes of determining dates of eligibility, the conditions which must be satisfied to become insured and the circumstances under which the insurance terminates, if different from this Plan. For additional information on this benefit please contact the Fund Office.

Termination of Coverage: Your life insurance benefit will terminate on the earliest of the following:
(1) The date the Plan is discontinued, or
(2) The date you no longer satisfy the eligibility requirements, or
(3) The date on which you withdraw from Active Service

Retirees: If you are a Retiree who is collecting a pension from the Sheet Metal Workers' Local No. 71 Pension Fund which is effective before January 1, 2020, and you were covered on this medical plan (other than through COBRA) at retirement, you will be entitled to a life insurance benefit in an amount of $5,000 through December 31, 2022, at which point the benefit will be terminated entirely. There is no Retiree Life Insurance Benefit for Employees retiring on or after January 1, 2020. This is a self-insured benefit paid from Plan assets.

Should you die while eligible, the death benefit will be paid to your Designated Beneficiary. Your Designated Beneficiary is the person(s) designated by you on a form provided by the Plan, except that a divorce will automatically revoke your prior spouse as Designated Beneficiary unless the divorce decree expressly provides otherwise. If you fail to designate a beneficiary, the death benefit will be paid to your estate. Your current beneficiary designation on file with the Plan under the prior insured arrangement will control until changed by you.

DISABILITY INCOME BENEFIT

Benefit: If you are an Employee in Active Service and are enrolled for Employee medical coverage or have filed an active Waiver under the Plan, on the form provided by the Fund Office, you will be entitled to the Disability Income Benefit. In the event you suffer a Disability, while in Active Service, you shall be entitled to receive a weekly disability benefit of One Hundred Dollars ($100.00) or Twenty Dollars ($20.00) a day for partial weeks. Your benefit will begin on the first (1st) day of disability if due to accidental bodily injury or the eighth (8th) day of disability if due to sickness. This benefit will be paid for a maximum period of twenty-six (26) weeks for each disability.

Disability: For purposes of this section, you shall be deemed Disabled if your physician certifies that you are totally disabled to perform your regular occupation and you submit proof of entitlement to Workers Compensation, NYS Disability or Social Security disability. To be entitled to this benefit your disability must have occurred while you were Eligible for coverage under this Plan and you must be under the care of a legally qualified physician. Disability due to self-inflicted injury or war is not Covered. Application for the Disability Benefit must be received by the Benefit Fund Office within 60 (sixty) days of the date the disability began or the claim will be denied. Disability forms are available at the Fund office. Forms must be completed by a licensed physician.

CLAIM AND APPEAL PROCEDURES

Medical and Dental Claims: When you receive medical or dental treatment you must present your identification (ID Card) at the time of your visit. All network providers submit claim forms for you. Benefit are then paid directly to the doctor or hospital providing the services. You will receive an explanation of benefits (EOB) for all claims received. Your ID Card provides the group and identification number the provider will need to submit your claim. While it is preferred that all claims be submitted electronically, paper claims may be mailed to the address in the Claims Administrators Section. If needed, paper claim forms can be requested from the Claims Administrator. Completed forms, along with any requested information, should be submitted to the Claims Administrator within 12 (twelve) months of the date of service.

Payments will be made directly to Network Preferred. All other payments will be made to the Employee unless there is an assignment of benefits on the claim.

Prescription Claims: Each time you need a prescription filled, be sure to present your ID card. Network pharmacies will submit claims electronically for you. If you need to submit a claim for a Direct Member Reimbursement, forms can be requested from the Claims Administrator. Completed forms, along with any requested information, should be submitted to the Claims Administrator within 90 (ninety) days of the date the prescription was filled. The Claims Administrator's address can be found in the Claims Administrators Section.

Disability Claims: If you need to submit a disability claim, forms are available from the Fund Office. The Fund Office contact information can be found in the Contact Information Section in the front of this book. Completed claim forms must be submitted to the Fund Office within 30 (thirty) days of the date the Disability began. Disability claim procedures are set forth separately below.

Life Insurance: If your beneficiary needs to file a life insurance claim, your beneficiary should contact the Fund Office. The Fund Office contact information can be found in the Contact Information Section in the front of this book. Claims for the life insurance benefit, will be reviewed in accordance with procedures contained in the insurance contract. These procedures are set forth in the booklets provided by the insurance Company. If you need an additional copy, you may obtain one free of charge from the Fund office. Life Insurance claim procedures are set forth separately below.

MEDICAL, PRESCRIPTION AND DENTAL CLAIMS CLAIMS ADMINISTRATORS

The Plan Administrator has contracted with the following Company(ies) to administer benefits and pay claims. You may contact the appropriate Claims Administrator directly, using the information listed below. Your Claims Administrator is listed on your ID card. The Plan Administrator will act as the claims administrator for the disability income benefit.

The Plan Administrator has also contracted with different third-party administrators, to handle certain day-to-day administrative functions such as utilization review, provider contracting and prescription benefit management for the Plan. While these service providers make every attempt to provide accurate information, mistakes can occur. It is important to understand that Federal law requires that the Plan documents always control, even if their terms conflict with information given to you by a service provider.

Medical, Dental, COBRA, Utilization Review
Nova Healthcare Administrators, Inc.
6400 Main Street, Suite 210
Williamsville, NY 14221
(716) 773-2122
www.novahealthcare.com

Prescription
Pharmacy Benefit Dimensions
511 Farber Lakes Drive
Buffalo, NY 14221
1 (888) 878-9172
www.pbdrx.com

DETERMINATION OF BENEFITS

A Determination of Benefits will be made for every claim submitted to the Claim Administrator. The Determination of Benefits will be made within time limits established under ERISA. Claims submitted by a Provider, the Covered Family Member, or an Authorized Representative will be paid according to the procedures described in this section.

A benefit that is denied for lack of Medical Necessity, because it is a non-Covered benefit, or because the Claim Administrator determines that the treatment is Experimental or Investigative will be considered an Adverse Determination.

The payment for any claim for a Covered Service is subject to clinical edits. The Plan will take into consideration appropriate health care practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the health care community or government oversight agencies. All services or procedures, unless specifically stated otherwise, are subject to Medical Necessity review. The Claim Administrator will also have the right to make Benefit Determinations based on the Claim Administrator's Policies and Procedures Manual developed in conjunction with the above standards of practice, and health care professionals.

TIME FRAMES FOR PROCESSING A CLAIM

Claims are divided into urgent care claims, concurrent care claims, pre-service health claims, and post-service health claims. If you or your representative fail to follow the Plan's procedures for filing a claim or if you file an incomplete claim, the Plan will notify you or your representative of the failure according to the time frames shown in the following chart.

If an initial claim is denied in whole or in part, you or your representative will receive written notice from the Plan Administrator. This notice will include the reasons for denial, the specific Plan provision involved, an explanation of how claims are reviewed, the procedure for requesting a review of the denied claim, a description of any additional material or information that must be submitted with the appeal, and an explanation of why it is necessary. If your claim for benefits is denied, you or your representative may file a written appeal for review of a denied claim with the PlanAdministrator.

The chart below shows the time frames for filing different types of claims with the Plan. If you have any questions about what type of claim you may have or the timing requirements that apply to your claim, please contact your Claims Administrator at the number shown on your ID cards.

Time Frames for Processing a Claim				
Claim Process	**Urgent Care Claim**	**Concurrent Care Claim**	**Pre-Service Health Claim**	**Post-Service Health Claim**
Claims Administrator determines initial claim is improperly filed (not filed according to Plan procedures) or is not complete	Within 24 hours after receipt of improper or incomplete claim (notification may be oral unless you or your representative request otherwise)	Within 24 hours after receipt of request for extension of urgent concurrent care	Within 5 days after receipt of improper or incomplete claim (notification may be oral unless you or your representative request otherwise)	Not applicable
Claims Administrator determines that you must submit additional information required to complete claim	Within 48 hours after receipt of notice that your claim is incomplete	Not applicable	Within 45 days after receipt of notice that additional information is required	Within 45 days after receipt of notice that additional information is required
Claims Administrator reviews claim and makes determination of:		For urgent care claims, within 24 hours after receipt of the claim, provided request is submitted at least 24 hours prior to expiration of prescribed period of time or number of treatments. If not submitted within 24 hours prior to expiration of prescribed period of time or number of treatments, not later than 72 hours after receipt of claim.* For non-urgent care claims, determination will be made within time frame designated for type of claim (pre- or post-service) and prior to expiration of prescribed period of time or number of treatments.*		
complete/proper claim	Within 48 hours after the earlier of: receipt of requested information, or at end of period allowed for you to provide information		Within 15 days after the earlier of: receipt of requested information, or at end of 45-day period allowed for you to provide information	Within 30 days after the earlier of: receipt of requested information, or at end of 45-day period allowed for you to provide information
initial claim	Within 24 hours of receipt of initial claim		Within 15 days of date initial claim is received	Within 30 days of date initial claim is received
Extension period,** if required due to special circumstances beyond control of Claims Administrator	Not applicable	Not applicable	Additional 15 days if Plan requires more information from you and provides an extension notice during initial 15-day period	Additional 15 days if Plan requires more information from you and provides an extension notice during initial 30-day period

* A request for extension of treatment will be deemed to be an initial claim. A reduction or termination of approved, ongoing treatment will be deemed to be an adverse claim decision. If the Claims Administrator makes an adverse decision, you will be notified of the reduction/termination within a time frame that allows you to submit an appeal and have a determination on the appeal prior to the expiration of the prescribed period of time or number of treatments.

** Whenever an extension is required, the Plan must notify you before the current determination period expires. The notice must state the circumstances requiring the extension and the date a determination is expected to be made.

How to Appeal a Claim: To appeal a denied claim or to review administrative documents pertinent to the claim, you or your representative must send a written request to the Plan. You may also appeal the Plan's decision to rescind your coverage due to fraud or intentional misrepresentation of material fact. The time frames for appealing a claim are shown in the following chart.

If you or your representative submit an appeal, state why you think your claim should be reviewed and include any data, documents, questions, or comments, along with copies of itemized bills and claim forms relating to your claim. You may request, free-of-charge,

copies of all documents, records, and other information relevant to your claim. A reviewer who did not make the initial claim determination will be responsible for reviewing your appeal. Also, you will be notified of any expert advice obtained on behalf of the Plan in reviewing the denied claim, regardless of whether such advice was relied upon in reviewing your claim. Such experts will not be individuals who were consulted in making the initial claim determination.

Time Frames for Appealing Denied Claims				
Appeal Process	**Urgent Care Claim**	**Concurrent Care Claim**	**Pre-Service Health Claim**	**Post-Service Health Claim**
You may submit an appeal of denied initial claim to the Claims Administrator	Within 180 days of receiving notice of denied claim	You will be notified of reduction or termination of benefit in time to submit appeal and receive determination before benefit ends	Within 180 days of receiving notice of denied claim	Within 180 days of receiving notice of denied claim
Claims Administrator reviews your first appeal and makes determination	Within 72 hours after appeal is received	Prior to reduction or termination of benefit	Within 15 days of date appeal is received	Within 30 days of date appeal is received
You may submit a second appeal to the Plan Administrator	N/A	N/A	Within 180 days of receiving notice of denied claim	Within 180 days of receiving notice of denied claim
The Plan Administrator reviews your second appeal and makes final determination	N/A	N/A	Within 15 days of date appeal is received	Within 30 days of date appeal is received

You will be notified of the Claim Administrator's decision in writing. If your claim is denied, the Claim Administrator will give you in writing the specific reason(s) that your claim was denied, the specific reference to the Plan provisions on which the denial was based, any internal rules, guidelines, protocols, or similar criteria used as basis for the decision, a statement that you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim, and a statement regarding your right to bring civil action in Federal court under Section 502(a) of ERISA.

The decision of the Plan Administrator, as to a disability benefit, shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law.

Exhaustion Required: If you do not file a claim, follow the claims procedures, or appeal a claim within the time frames permitted, you will give up all legal rights, including your right to file suit in Federal court, as you will not have exhausted your internal administrative appeal rights. Participants or claimants must exhaust all remedies available to them under the Plan before bringing legal action. Additionally, legal action may not be brought against the Plan more than one year after a final decision on appeal has been reviewed under the Plan.

External Review Rights: If, after exhausting your internal appeals, you are not satisfied with the determination made by the Claims Administrator, you may be entitled to request an external review of the Claims Administrator's decision. You will be notified in writing that your claim is Eligible for an external review and you will be informed of the time frames and the steps necessary to request an external review. In most cases, you must complete all levels of the internal claims and appeal procedure before you can request a voluntary external review.
External review is only available for Adverse Benefit Determinations that involve medical judgment or a rescission of coverage.

If you decide to seek external review, an independent external review organization (an "IRO") will be assigned your claim. The IRO does not have to give deference to any earlier claims and appeals decisions, but it must observe the written terms of the Plan document. In other words, the IRO is not bound by any previous decision made on your claim. The ultimate decision of the IRO will be binding on you, the Claims Administrator and the Plan.

There are two types of external review:

(1) Standard external review

(2) Expedited external review

You or your representative may request a standard external review, or an expedited external review in urgent situations, by following the directions in the determination letter. A request for an external review must be made within four months after the date you received Claims Administrator's decision.

Standard External Review: A standard external review involves the following steps:

(1) The Claims Administrator performs a preliminary review.
(2) The Claims Administrator refers the review request to the IRO.
(3) The IRO makes a decision.

Within the applicable timeframe after receipt of the request, the Claims Administrator will complete a preliminary review to determine whether you meet all of the following requirements:

(1) You were Covered under the Plan at the time the health care item or service was provided (or requested for a pre-service claim).
(2) The Adverse Benefit Determination does not relate to your failure to meet the Plan's eligibility criteria.
(3) You have exhausted the Plan's applicable internal appeals process (unless the Claims Administrator did not adhere to the claims and appeals requirements).
(4) You have provided all the information and forms required so that the Claims Administrator may process your external review request.

After the Claims Administrator completes the preliminary review, it will issue a notification in writing to you. If your request is complete but not Eligible for external review, the Claims Administrator's notice will provide (1) the reasons your request is not Eligible and (2) contact information for the Employee Benefits Security Administration. If your request is not complete, the notice will describe the missing information or materials. The Claims Administrator will then allow you to complete the request for external review before the end of the original four-month filing period or within 48 hours, whichever is later.
If the request is Eligible for external review, the Claims Administrator will assign an IRO to conduct the review and provide the IRO with the materials considered during the internal appeals process. The IRO will timely notify you in writing to (1) confirm your request is Eligible for external review and (2) inform you that you may submit in writing, within ten business days following the date of receipt, additional information that the IRO should consider when conducting the external review. The IRO will forward any additional information you provide to the Claims Administrator so that it may consider whether to approve your claim based on the new information.

The IRO will provide written notice of its determination within 45 days after it receives the request for the external review. The IRO will deliver the notice of its determination to you and the Claims Administrator, and it will include the clinical basis for the determination.

If the IRO's decision reverses the Claims Administrator's determination, the Plan will provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the IRO's determination is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the health care item or service.

Expedited External Review: An expedited external review is similar to a standard external review. The main difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive any of the following:

(1) An Adverse Benefit Determination involving a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if you followed the guidelines for an expedited internal appeal and you have filed a request for an expedited internal appeal;
(2) A final internal Adverse Benefit Determination involving a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if you followed the guidelines for a standard external review; or
(3) A final internal Adverse Benefit Determination involving an admission, availability of care, continued stay, or a health care item or service for which you received Emergency services, but have not been discharged from the facility.

Immediately upon receipt of your request, the Claims Administrator will determine whether the request is Eligible for expedited external review and will immediately send you a notice of its eligibility determination.

If the Claims Administrator determines that your request is Eligible for an expedited external review, the Claims Administrator will assign an IRO. The IRO will render a decision as quickly as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, the assigned IRO will provide you, the Claims Administrator, and the Plan with written notification of its decision within 48 hours.

For additional information about the external IRO process, contact the Claims Administrator at the telephone number shown on your ID card.

Disability Claims: If you are filing a claim for disability income benefits, you should follow the claims procedure set forth in this section.

In order to make a claim for benefits for any of these benefits, you are generally required to submit to the Fund Office a completed claim form available from the Fund Office, along with any required documentation.

If your claim for benefits is denied, in whole or in part, or any other adverse benefit determination has been made, the Plan Administrator will notify you (or your duly authorized representative) within 45 days of receiving your claim

In the case of a claim for disability benefits, there may be two extension periods of up to 30 days each, provided that the Plan Administrator determines that such an extension is necessary due to circumstances beyond the control of the Plan. In the event of such an extension, notice of the extension will be provided to you before expiration of the initial 45-day period (or before expiration of the first 30- day extension, in the case of a second extension). The notice will explain the circumstances requiring the extension and inform you of the date by which the Plan Administrator expects to make a decision. The notice will also specifically explain the standards on which entitlement to the benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and you will be afforded at least 45 days in which to provide the specified information.

In the case of a claim for disability benefits, if an extension is required due to your failure to submit information necessary to decide the claim, the period for making the determination will be tolled from the date on which the extension notice is sent to you until the earlier of: (i) the date on which you respond to the Plan Administrator's request for additional information, or (ii) expiration of the 45-day period within which you must provide the requested additional information.

If your claim for a benefit is denied, in whole or in part, or any other adverse benefit determination has been made, you will be sent written notice explaining:

(1) the specific reason(s) for the denial or other adverse benefit determination;
(2) the exact plan provision(s) on which the decision was based;
(3) what additional material or information is needed to process your claim and why such material or information is needed;
(4) what procedures you should follow to get your claim reviewed again by the Board of Trustees, and the time limits applicable to such procedures; and
(5) a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

In addition to the above notification requirements, notification with regards to a disability claim shall also include:

(1) A discussion of the decision, including any reasons for disagreeing with the views of any treating professionals, medical or vocational experts consulted, or a Social Security Administration determination; and
(2) A description of any internal rule, guideline or similar standard that the Fund relied on in making a decision based on medical necessity, experimental treatment or a similar limitation, or statement that such explanation will be provided (without charge) upon the claimant's request; and
(3) A description of any scientific or clinical judgment that the Fund relied on in making a decision based on medical necessity, experimental treatment or a similar limitation, or a statement that such explanation will be provided (without charge) upon the claimant's request.

Disability Claim Review Procedure:

If your claim is denied, or any other adverse benefit determination is made, you have a right to request a review of that determination.

In order to do so, you (or your authorized representative) must, within 180 days after you receive the notice of denial, submit your written request for review to the Board of Trustees. In the case of an adverse benefit determination regarding a rescission of disability coverage, the claimant must request a review within 90 days of the notice.

In connection with your request for review, you (or your authorized representative) may submit written comments, documents, records or other information relating to your claim. The review will take into account all comments, documents, records and other information you submit relating to your claim, regardless of whether they were submitted in connection with your initial claim for benefits.

For Disability Pension Income claims, a different person will review your claim than the one who originally denied the claim and the reviewer will not be a subordinate of the person who originally denied the claim. You will be advised of the identity of any medical or vocational expert who were consulted in connection with the initial denial. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you. In addition, if your claim was denied on the basis of a medical judgment, a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted. The health care professional will not be the same person who was consulted with respect to the initial adverse benefit determination (or a subordinate of such person).

If the Trustees consider, rely upon or create any new or additional evidence during the review of the adverse benefit determination, they will provide such new or additional evidence to you, free of charge, as soon as possible and sufficiently in advance of the time within which a determination on review is required to allow you time to respond.

Before the Trustees issue an adverse benefit determination on review that is based on a new or additional rationale, you will be provided a copy of the rationale at no cost. The rationale will be provided as soon as possible and sufficiently in advance of the time within which a final determination on appeal is required to allow the claimant time to respond.

A decision on review will be made by no later than the date of the meeting of the Board of Trustees immediately following the plan's receipt of your request for review, unless the request is received within 30 days of the meeting, in which case the determination will be made by no later than the date of the second meeting following the plan's receipt of the request. If the Board of Trustees determines that special circumstances require an extension of time for processing, then the decision on review will be made by no later than the third meeting following the Plan's receipt of the request for review. You will be notified of the extension in writing before the extension begins, and the extension notice will indicate the special circumstances requiring the extension as well as the date by which the Board of Trustees expects to make the determination on review. You will be notified of the determination on review within 5 days after the determination is made.

You will be notified in writing of the determination on review. The notification will include all of the information described above, with respect to the initial review.

Claims for Life Insurance Benefits:

In order to make a claim for Life Insurance Benefits, you should submit to the Fund Office an original death certificate (and any other required documentation). If your claim for benefits is denied, in whole or in part, or any other adverse benefit determination has been made, you (or your duly authorized representative) will be notified within 90 days of receiving your claim. The 90-day period may be extended for an additional 90 days if special circumstances require extra time to process your claim. You will receive written notice of the extension and the reasons for it, as well as the date by which the Plan Administrator expects to make the benefit determination, before the end of the initial 90-day period.

If your claim for a benefit is denied, in whole or in part, or any other adverse benefit determination has been made, you will be sent written notice explaining:

(1) The specific reason(s) for the denial or other adverse benefit determination;
(2) The exact plan provision(s) on which the decision was based;
(3) What additional material or information is needed to process your claim and why such material or information is needed;
(4) What procedures you should follow to get your claim reviewed again, and the time limits applicable to such procedures;
(5) A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

If your claim is denied, or any other adverse benefit determination is made, you have a right to request a review of that determination. In order to do so, you (or your authorized representative) must, within 60 days after you receive the notice of denial, submit your written request for review directly to the life insurance company. In connection with your request for review, you (or your authorized representative) may submit written comments, documents, records or other information relating to your claim. The review will take

into account all comments, documents, records and other information you submit relating to your claim, regardless of whether they were submitted in connection with your initial claim for benefits. In addition, you will be provided, upon written request and free of charge, with reasonable access to (and copies of) all documents, records and other information relevant to your claim. A document, record or other information is considered relevant to your claim if it was relied upon by in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); or it demonstrates compliance with the organization's administrative processes for ensuring consistent decision-making. A decision on review will be made by the Board of Trustees no later the date of the meeting of the Board of Trustees immediately following the plan's receipt of your request for review, unless the request is received within 30 days of the meeting, in which case the determination will be made by no later than the date of the second meeting following the plan's receipt of the request. If the Board of Trustees determines that special circumstances require an extension of time for processing, then the decision on review will be made by no later than the third meeting following the Plan's receipt of the request for review. You will be notified of the extension in writing before the extension begins, and the extension notice will indicate the special circumstances requiring the extension as well as the date by which the Board of Trustees expects to make the determination on review. You will be notified of the determination on review within 5 days after the determination is made.

You will be notified in writing of the determination on review. The notification will include all of the information described above, with respect to the initial review.

RESPONSIBILITIES OF THE PLAN ADMINISTRATOR

Named Fiduciaries: The named fiduciary of the Plan is the Board of Trustees, which is also the Plan Administrator.

The named fiduciary shall have separate authority to control and manage the operation and administration of the Plan. Every fiduciary and other person who handles funds or other property of this Plan shall be bonded in accordance with Section 412 of ERISA.

Advisors to Fiduciaries: A named fiduciary or his delegate may employ actuaries, attorneys, accountants, brokers, Employee benefit consultants, and other specialists to give advice concerning any responsibility such fiduciary has under this Plan.

Duties of the Plan Administrator: The Plan Administrator has the authority and responsibility to:

(1) Design this Plan, including the right to amend or terminate the Plan, and
(2) Establish the policies, interpretations, practices and procedures of this Plan, except to the extent such responsibility has been allocated to the Claim Administrator, and
(3) Hire the Claim Administrator and all persons providing services to the Plan, and
(4) Authorize payment of the Plan's administrative expenses, and
(5) Purchase stop-loss coverage if the Plan Administrator decides that such coverage is desirable. The Plan Administrator shall be under no obligation to acquire such coverage on behalf of the Plan, and
(6) Act as this Plan's agent for the service of legal process, and
(7) Perform all other responsibilities allocated to the Plan Administrator in the instrument appointing the Plan Administrator, and
(8) Comply with the requirements imposed upon the Plan Administrator under the COBRA continuation coverage provisions and applicable regulations, and
(9) Comply with ERISA's reporting and disclosure requirements, and
(10) Receive all disclosures required of fiduciaries and other service providers under ERISA or any other federal or state law.
(11) Comply with the HIPAA Privacy Regulation to ensure compliance with regard to the use and disclosure of any Covered Family Member's Protected Health Information.

Discretion of Plan Administrator:

(1) The Plan Administrator shall have the absolute authority and discretion to construe any uncertain or disputed term or provision in the Plan. This includes, but is not limited to, the following:

    (A) Determining whether an individual is Eligible for benefits under this Plan, and
    (B) Determining the amount of benefits, if any, an individual is entitled to under this Plan, and
    (C) Interpreting all of the provisions of this Plan, and
    (D) Interpreting all of the terms used in this Plan.

(2) The Plan Administrator's exercise of this discretionary authority shall:

(A) Be binding upon all interested parties, including, but not limited to, the Covered Family Member, the Covered Family Member's estate, any beneficiary of the Covered Family Member and the Employer, and

(B) Be entitled to deference upon review by any court, agency or other entity empowered to review the Plan Administrator's decisions, to the fullest extent permitted by law, and

(C) Not be overturned or set aside on such review, unless found to be arbitrary and capricious, or made in bad faith.

If the Plan Administrator is a committee and if discretionary authority must be exercised against a member of the committee, the Plan Administrator's discretionary authority under this Plan must be exercised solely and exclusively by the other members of the committee. If the Plan Administrator is an individual, and discretionary authority is to be exercised against him as an individual, discretionary authority shall be exercised by an officer of the Employer.

Funding Policy: Plan Benefits are funded by contributions under the Collective Bargaining Agreement. Plan Benefits shall be set at a level that the Plan Administrator believes to be consistent with the Plan's short-term and long-term objectives and financial needs, taking into account the need for liquidity to pay benefits. All actions taken pursuant to this section and the reasons for such action shall be recorded in the minutes of any meeting.

Co-Fiduciary Liability: No fiduciary shall have any liability for a breach of fiduciary duty of another fiduciary, unless he participates knowingly in such breach, knowingly undertakes to conceal such breach, has actual knowledge of such breach and fails to take action to remedy such breach, or, through his negligence in performing his own specific fiduciary responsibilities, he has enabled such other fiduciary to commit a breach of the latter's fiduciary duty.

RESPONSIBILITIES OF THE PRIVACY OFFICER

Duties of the Privacy Officer: The Privacy Officer has the authority and responsibility to:

(1) Ensure the compliance of all Plan Documents with the HIPAA Privacy Regulation.

(2) Establish written policies and procedures for the Plan to ensure the privacy rights of Covered Family Members regarding Protected Health Information.

(3) Establish a process to handle complaints by a Covered Family Member, including sanctions for employees and Business Associates who fail to comply with the Plan regarding the HIPAA Privacy Regulation.

(4) Develop a Notice of Privacy Practices regarding Protected Health Information and distribute the notice to Employees Covered under the Plan.

(5) Develop a program for training employees including certification that training has been completed.

(6) Audit compliance with the HIPAA Privacy Regulation.

(7) Ensure that the Plan does not use or disclose more than the minimum necessary Protected Health Information to carry out the intended purpose.

(8) Identify the Plan’s Business Associates and require a written agreement with the Plan’s Business Associates that outlines their duties and responsibilities with respect to HIPAA and the Plan.

(9) Maintain records and, when required, prepare an accounting of all uses and disclosures of Protected Health Information made outside of Treatment, Payment, or Health Care Operations. The record must contain an accounting of all disclosures for up to six years from the date of the first disclosure.

(10) Allow the Covered Family Member access to view, copy and amend their Protected Health Information.

(11) Discipline, sanction, or terminate any person for use or disclosure of any Protected Health Information outside of Treatment, Payment or Health Care Operations.

(12) Mitigate the adverse effects of the unauthorized use of Protected Health Information.

(13) Ensure continuing compliance with 45 Code of Federal Regulations, as it may be amended from time to time.

RESPONSIBILITIES OF THE CLAIM ADMINISTRATOR

Appointment of the Claim Administrator: The Claim Administrator shall be appointed by the Plan Administrator.

Claim Administrator's Responsibilities: A Claim Administrator's authority and responsibility shall be limited to that portion of the Plan that it has been authorized by the Plan Administrator to administer. The Claim Administrator shall have the authority and responsibility to:

(1) Interpret this Plan's provisions relating to coverage except where the Claim Administrator requests an interpretation, a claimant files an appeal with the Plan Administrator, or the Plan Administrator exercises its authority on its own volition. In said case, the Plan Administrator shall interpret the Plan and shall communicate in writing to the Claim Administrator the appropriate interpretation of the Plan.
(2) Administer this Plan's claim procedure.
(3) Pay benefits under the Plan by drawing checks against the claim account.
(4) Advise or otherwise assist the Plan Administrator or Employer in connection with the purchase of stop-loss coverage, if any, for the benefits provided under the Plan.
(5) File claims with the insurance companies, if any, who issue stop-loss insurance policies to the Employer.
(6) Perform all other responsibilities delegated to the Claim Administrator in the instrument appointing the Claim Administrator.
(7) Adhere to the HIPAA Privacy Regulation applicable to a Business Associate by complying with the provisions of the Business Associate agreement.

PLAN INTERPRETATION

Word Usage: Whenever words are used in this document in the singular or masculine form, they shall, where appropriate, be construed so as to include the plural, feminine or neuter form.

Court of Competent Jurisdiction: In the event that a court of competent jurisdiction shall determine in a final judgment or decree that one or more of the provisions of this Plan is invalid due to the provisions of applicable law, this Plan shall be interpreted as if the offending language had been stricken from its provisions and the remainder of the Plan shall continue in full force and effect.

HIPAA PRIVACY AND SECURITY

Introduction: Employees of the Fund have access to the individually identifiable health information of Plan participants for administration functions of the Plan. When this health information is provided from the Plan to the Plan Sponsor, it is Protected Health Information (PHI) and, if it is transmitted by or maintained in electronic media, it is Electronic PHI.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Plan Sponsor's ability to use and disclose PHI and Electronic PHI. The following HIPAA definitions of PHI and Electronic PHI apply to this Section:

"Protected Health Information (PHI)" means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe that the information can be used to identify the individual. Protected health information includes information of persons living or deceased.

"Electronic Protected Health Information (Electronic PHI)" means Protected Health Information that is transmitted by or maintained in electronic media.

The Plan Sponsor will have access to PHI and Electronic PHI from the Plan only as permitted under this section or as otherwise required or permitted by HIPAA.

PROVISION OF PROTECTED HEALTH INFORMATION TO PLAN SPONSOR

Permitted Disclosure of Enrollment/Disenrollment Information: The Plan may disclose to the Plan Sponsor information on whether the individual is participating in the Plan.

Permitted Uses and Disclosure of Summary Health Information: The Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose Summary Health Information to the Plan Sponsor, provided that the Plan Sponsor requests the Summary Health Information for the purpose of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending, or terminating the Plan.

"Summary Health Information" means information (1) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under the Plan; and (2) from which the information described at 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR §164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes: Unless otherwise permitted by law, and subject to the conditions of disclosure described below and obtaining the written certification of the Plan Sponsor, the Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose PHI and Electronic PHI to the Plan Sponsor, provided that the Plan Sponsor uses or discloses such PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Plan Sponsor on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring.

Plan administration shall also include the filing of a claim with the Department of Health and Human Services ("HHS") under the retiree reinsurance program established pursuant to Section 1102 of the Patient Protection and Affordable Care Act. The Plan shall disclose to the Secretary of HHS, on behalf of the Plan Sponsor, at such time and in such manner specified by the Secretary in guidance, information, data, documents, and records necessary for the Plan Sponsor to comply with the requirements of the program.

Notwithstanding any provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI or Electronic PHI in a manner that is inconsistent with 45 CFR §164.504(f).

Conditions of Disclosure for Plan Administration Purposes: Plan Sponsor agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508, which are not subject to these restrictions) disclosed to it by the Plan (or a health insurance issuer or HMO on behalf of the Plan), Plan Sponsor shall:

(1) Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;
(2) Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;
(3) Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of a participating Employer;
(4) Report to the Plan any use or disclosure of the PHI of which it becomes aware that is inconsistent with the uses or disclosures provided for;
(5) Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR §164.524;
(6) Make available PHI for amendment, and incorporate any amendments to PHI, in accordance with 45 CFR §164.526;
(7) Make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528;
(8) Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of HHS for purposes of determining compliance by the Plan with HIPAA's privacy requirements;
(9) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible, and;
(10) Ensure that the adequate separation between Plan and Plan Sponsor (i.e., the firewall) required by 45 CFR §504(f)(2)(iii), is established.

Plan Sponsor further agrees that if it creates, receives, maintains, or transmits any Electronic PHI (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508, which are not subject to these restrictions) on behalf of the Plan, it will:

(1) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

(2) Ensure that the adequate separation between the Plan and the Plan Sponsor (i.e., the firewall), required by 45 CFR §504(f)(2)(iii) is supported by reasonable and appropriate security measures;

(3) Ensure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information, and;

(4) Report to the Plan any security incident of which it becomes aware, as follows: Plan Sponsor will report to the Plan, with such frequency and at such times as agreed, the aggregate number of unsuccessful, unauthorized attempts to access, use, disclose, modify, or destroy Electronic PHI or to interfere with systems operations in an information system containing Electronic PHI; in addition, Plan Sponsor will report to the Plan as soon as feasible any successful unauthorized access, use, disclosure, modification, or destruction of Electronic PHI or interference with systems operations in an information system containing Electronic PHI.

Adequate Separation between Plan and Plan Sponsor: The Plan Sponsor shall allow Fund employees access to the PHI. No other persons shall have access to PHI. These employees shall only have access to and use of PHI to the extent necessary to perform the plan administration functions needed for successful operation of the Plan. In the event that any of these specified employees does not comply with the provisions of this Section, that Employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's Employee discipline and termination procedures.

The Plan Sponsor shall ensure that the provisions of this subsection are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain, or transmit Electronic PHI on behalf of the Plan.

Sponsor Contact Information: The Plan Sponsor may be reached at:

Board of Trustees
c/o John Helak, Business Manager/Trustee
Sheet Metal Workers Local #71 and
Industry Welfare Fund
24 Liberty Avenue
Buffalo, NY 14215
(716) 835-8836

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits: This includes the ability to:

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

(2) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

(3) Receive a summary of the Plan's annual financial report (Form 5500 Series). The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage: You have a right to:

(1) 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 Plan document and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

(2) You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Prudent Actions by Plan Fiduciaries: In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical Child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

Assistance With Your Questions: If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Qualified Medical Child Support Orders: The Plan provides medical benefits in accordance with the applicable requirements of any "Qualified Medical Child Support Order" as required under ERISA. A Qualified Medical Child Support Order is any judgment, decree, or order (including approval of a property settlement agreement) issued by either a court of competent jurisdiction or through an administrative ruling that has the force and effect of state law which:

(1) Relates to the provision of Child support with respect to the Child of an Employee or COBRA Beneficiary under this Plan or provides for health benefit coverage to such a Child, and is made pursuant to a state domestic relations law (including a community property law), and relates to such coverage under this Plan, or

(2) Enforces a law relating to medical Child support described in Section 1908 of the Social Security Act with respect to this Plan, and which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to receive benefits payable with respect to a beneficiary under this Plan. For purposes of this section, an "alternate recipient" shall mean any Child of an Employee or COBRA Beneficiary who is recognized by a Qualified Medical Child Support Order as having a right to enrollment under a group health plan with respect to such an Employee or COBRA Beneficiary, and

(3) Satisfies the requirements of Section 609 of ERISA.

A procedure has been established to determine if a Qualified Medical Child Support Order exists. You may obtain a copy of the procedure at no charge from your Employer.

Newborns' and Mothers' Health Protection Act: Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your Plan Administrator.

Women's Health and Cancer Rights Act: Under this Federal law, group health plans that provide medical and surgical benefits for mastectomies must provide coverage in connection with the mastectomy, in the manner determined by the attending physician and the patient for:

(1) Reconstruction of the breast on which the mastectomy was performed, or
(2) Surgery and reconstruction of the other breast to produce a symmetrical appearance, or
(3) Prostheses and treatment of physical complications at all stages of mastectomy, including lymphedema.

Group health plans and health insurers may not deny eligibility to enroll, renew or continue group health plan coverage to avoid providing coverage for breast reconstruction or mastectomy complications. Further, the law prohibits:

(1) Penalizing or otherwise reducing or limiting the reimbursement of an attending Provider for the required care, or
(2) Providing any incentive (monetary or otherwise) to induce the attending Provider to provide care that would be inconsistent with the law.

The above-described coverage required by the law may only be subject to the annual deductibles, Copayments, and Coinsurance provisions that apply to similar benefits.

Certification of Compliance with Privacy Regulations: A Federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your Protected Health Information. A complete description of your privacy rights under HIPAA can be found in the Notice of Privacy Practices you received when you enrolled. A copy is available upon request from the Employer.

Under HIPAA you have certain rights with respect to your Protected Health Information, including but not limited to, the right to see and copy the information, receive an accounting of certain disclosures of the information and to amend the Protected Health Information under certain circumstances.

Protected Health Information that is used for Treatment, Payment or Health Care Operations may be disclosed without your written authorization. The Plan will only disclose the minimum necessary Protected Health Information permitted or required by law.

The following employees or classes of employees or other workforce members under the control of the Employer may be given access to Plan participants' Protected Health Information relating to Treatment, Payment, or Health Care Operations received from the Plan or a health insurance or Business Associate servicing the Plan:

(1) The Plan Administrator, and
(2) Staff designated by the Plan Administrator.

Protected Health Information that is not related to Treatment, Payment or Health Care Operations is protected by HIPAA and will not be used or disclosed without your written authorization unless required by law. The Covered Family Member must authorize the use or disclosure of Protected Health Information for employment-related actions or decisions and in connection with any other benefit or Employee benefit plan.

The Notice of Privacy Practices includes a complete description of your privacy rights under this Plan. You may request a copy of the Notice of Privacy Practices from the Employer or the Privacy Officer.

If you believe your privacy rights have been violated, you may file a complaint with the Plan in care of the Privacy Officer. You may also file a complaint with the Secretary of the Department of Health and Human Services, Hubert Humphrey Building, 200 Independence Ave., S.W., Washington, D.C. 20201. The Plan will not retaliate against you for filing a complaint.

Authority to Construe and Apply Plan Documents: To the full extent permitted by law, the Plan Administrator (and its designees) shall have the sole discretionary authority to:

(1) Construe any uncertain or disputed term or provision of the Plan, and

(2) Decide all questions concerning the Plan and their application (including, but not limited to, determining eligibility questions, benefit questions, and questions of fact and/or law). The exercise of this discretionary authority shall be binding upon all interested parties, including, but not limited to, you, your estate and your beneficiaries.

The Plan Administrator is the "Named Fiduciary" of the Plan for all purposes of ERISA. The Named Fiduciary may appoint advisors and may act in more than one capacity.

GENERAL PLAN INFORMATION

The Fund is Administered by: PLAN NAME:	Sheet Metal Workers Local No. 71 Healthcare Plan
PLAN NUMBER:	501
PLAN SPONSOR:	Sheet Metal Workers Local #71 Industry Welfare Fund 24 Liberty Avenue Buffalo, New York 14215
EMPLOYER IDENTIFICATION NO:	16-0864434
TYPE OF PLAN:	Welfare Benefit Plan for Medical, Dental and Prescription Benefits
PLAN ADMINISTRATOR AND AGENT FOR SERVICE OF LEGAL PROCESS:	Board of Trustees/John Helak, Business Manager Local #71 Sheet Metal Workers Local #71 Industry Welfare Fund 24 Liberty Avenue Buffalo, New York 14215 (716) 835-8836
SOURCES OF CONTRIBUTIONS:	The Plan is funded by employer contributions pursuant to a collective bargaining agreement
TYPE OF ADMINISTRATION:	**Third Party Administrator for Medical and Dental Benefits:** Nova Healthcare Administrators, Inc. 6400 Main Street, Suite 210 Williamsville, NY 14221 **Third Party Administrator for Pharmacy Benefits:** Pharmacy Benefit Dimensions 511 Farber Lakes Drive Buffalo, NY 14221
PLAN YEAR:	Plan records are kept on a Plan Year basis beginning on January 1st and ending December 31st.
SOURCE OF FUNDING:	Benefits shall be paid from the assets of the Plan and from the trust established in accordance with the trust agreement.
STOP LOSS INSURANCE:	A stop loss policy is provided.
PARTICIPANT EMPLOYER:	None
PRIVACY OFFICER:	John Helak Sheet Metal Workers Local #71 Industry Welfare Fund 24 Liberty Avenue Buffalo, New York 14215 (716) 835-8836