PLAN DOCUMENT
SUMMARY PLAN DESCRIPTION

FOR

SHEET METAL WORKERS LOCAL UNION 268 WELFARE PLAN

AS AMENDED AND RESTATED AS OF JULY 1, 2022

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SECTION A. PURPOSE

The Board of Trustees of the Sheet Metal Workers Local Union 268 Welfare Plan adopts this Welfare Plan under the terms of the Agreement and Declaration of Trust, in order to establish provisions which determine the eligibility of active and retired Employees for the benefits provided by the Sheet Metal Workers Local Union 268 Welfare Plan and to prescribe the amount, extent, conditions, and methods of payment of such benefits.

SECTION B. INTRODUCTION

This is the Sheet Metal Workers Local Union 268 Welfare Plan ("the Plan") for medical, prescription drug, and short-term disability benefits, as amended and restated as of July 1, 2022. In the event of any conflict between this document and any other document or oral communication, this document will control.

The Plan Sponsor reserves the right to terminate or amend the Plan at any time and for any reason subject to the terms of any relevant collective bargaining agreement.

The Plan will pay benefits only for the eligible expenses incurred while this coverage is in force. Benefits are not payable for eligible expenses incurred before coverage began or after coverage terminates. An expense for a service or supply is incurred on the date the service or supply is furnished.

As used in this document, the word "year" refers to a calendar year. All annual benefit maximums and deductibles accumulate during the calendar year. The word "Lifetime" as used in this document refers to the period of time that a Plan Participant is covered under the Sheet Metal Workers Local Union 268 Welfare Plan.

Federal regulations require us to advise you that the Sheet Metal Workers Local Union 268 Welfare Plan believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime dollar limits on benefits.

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

Board of Trustees of the Sheet Metal Workers
Local Union 268 Welfare Plan
2701 North 89th Street
Caseyville, Illinois 62232
618-397-1443

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

Defined terms are capitalized and defined in the "Defined Terms" section. This document is divided into the following sections:

- **Schedule of Medical and Prescription Drug Benefits.** Provides a description of the Plan's benefits.
- **Defined Terms.** Defines Plan terms that have a specific meaning.
- **Eligibility and Commencement of Coverage Provisions.** Explains eligibility and when coverage begins under the Plan.
- **Termination of Coverage and Extension of Coverage Provisions.** Explains when a Plan Participant's coverage would end and when a Plan Participant may extend coverage under the Plan.
- **COBRA Continuation Coverage.** Explains coverage continuation options available under the Plan.
- **Medical Management.** Explains the Medical Management Program, which protects a Covered Person from significant health care expenses and helps to provide quality care. This section should be read carefully since each Plan Participant is required to take action to assure that the maximum payment levels under the Plan are paid.
- **Medical Benefits.** Provides a description of medical benefits available under the Plan.
- **Plan Exclusions.** Lists services, treatment and charges incurred that are not covered by the Plan.
- **Prescription Drug Benefits.** Explains benefits provided under the independent drug program.
- **Short-Term Disability Benefits.** Provides a description of short-term disability benefits available under the Plan.
- **Filing a Claim.** Explains how to submit a claim for consideration of benefits under the Plan.
- **Claims Procedures.** Explains the procedures for filing a claim and the claim appeal process.

- **Coordination of Benefits.** Explains the Plan benefit payment order when a Covered Person is covered under more than one plan providing benefits.
- **Assignment and Other Benefit Payment Provisions.** Explains certain Plan provisions addressing payment of benefits.
- **Third Party Recovery Provision.** Explains the Plan's rights to recover payment of expenses when a Covered Person has a claim against another person because of injuries sustained.
- **Plan Administration, Amendment and Termination.** Explains the provisions governing administration, amendment and termination of the Plan.
- **Health Information Privacy and Security.** Summary of the Plan's HIPAA Privacy Policy and Security.
- **General Plan Information.** Provides general Plan information.

SECTION C. BENEFIT SCHEDULES

1. Medical And Prescription Drug Benefits In General

All benefits described in the Schedule of Medical and Prescription Drug Benefits are subject to the exclusions and limitations described in the Plan Exclusions section.

a. Preferred Provider Organization

The Plan includes an arrangement with a Preferred Provider Organization. The current Preferred Provider Organization is Meritain Health (an Aetna Company).

Meritain has agreements with certain Hospitals, Physicians and other health care providers, which are called Participating or In-Network Providers. These Participating Providers have agreed to charge reduced fees to Covered Persons covered under the Plan. The Plan saves money because services are performed at a lower cost, the provider gains new clientele, and the plan Participant receives a cost-effective benefit.

When a Covered Person uses a Participating Provider, the Plan will pay a larger amount than when a Non-Participating or Out-of-Network Provider is used. It is the Covered Person's option to select a Participating or Non-Participating Provider.

The Plan uses the Aetna Choice POS II Network (also known as the Aetna Choice POS II & MO IL Coventry Mitigation Network). Providers in that network ("Participating Providers") offer incentives over the use of Out-of-Network Providers.

It is the Covered Person's responsibility to verify a provider's current participation as a Participating Provider. You can find a directory of Participating Providers on the website shown on your identification card. These Network Provider Directories will be updated at least every 90 days. If you receive inaccurate information from the Directory (or in response to an inquiry to Aetna or the Fund Office) indicating that a Provider is a Participating Provider, services and supplies provided by that Non-Network Provider will be covered as if the provider was a Participating Provider.

Please note that benefits for services performed by a Non-Network Provider will be paid at the Out-of-Network rate, even if you were referred to that Non-Network Provider by a Participating Provider except in the case of Emergency Services and those services described

below under **Non-Emergency Services or Supplies from a Non-Network Provider at a Network facility.**

Non-Emergency Services or Supplies from a Non-Network Provider at a Network Facility. With regard to non-Emergency Services or supplies that are otherwise covered by the Plan, if such services or supplies are provided by or performed by a Non-Network Provider at a Network facility, the services or supplies are covered by the Plan:

- With a cost-sharing requirement that is not greater than the cost-sharing requirement that would apply if the services or supplies had been furnished by a Participating Provider;
- By calculating the cost-sharing requirement as if the total amount that would have been charged for the services or supplies by a Participating Provider were equal to the Recognized Amount for the services and supplies; and
- By counting cost-sharing payments you make with respect to Non-Network non-Emergency Services or supplies toward your In-Network deductible and In-Network out-of-pocket maximum.

Notice and Consent Exception: Non-Emergency Services or supplies performed by a Non-Network Provider at a Network facility will be covered based on your Non-Network coverage if:

- At least 72 hours before the day of the appointment (or three hours in advance of services rendered in the case of a same-day appointment), you are given written notice by the provider, as required by federal law, stating
  - that the provider is a Non-Network Provider with respect to the Plan,
  - the estimated charges for your treatment and any advance limitations that the Plan may apply to your treatment,
  - the names of any Participating Providers at the facility who are able to treat you, and
  - that you may elect to be referred to one of the Participating Providers listed; and
- You give informed consent to continued treatment by the Non-Network Provider, acknowledging that you understand that such continued treatment may result in greater cost to you.

The notice and consent exception does not apply to Ancillary Services and services or supplies furnished as a result of unforeseen, urgent medical needs that may arise at the time a service or supply is furnished, regardless of whether the Non-Network Provider satisfied the notice and consent criteria.

Continuity of Care. If you are a Continuing Care Patient and your provider's status changes from a Participating Provider to Non-Network, the Plan will notify you in a timely manner of your right to elect continued transitional care from the provider for a period of up to 90 days at the applicable In-Network cost sharing levels.

b. Prior Notification and Precertification

For certain services a Covered Person is required to notify Meritain Medical Management prior to the admission in order to enable Meritain Medical Management to pre-certify the services.

Plan does not require prior notification for a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

To provide prior notification call: Meritain Medical Management at 800-242-1199.

Detailed information regarding the prior notification requirement and the penalty for failure to provide prior notification can be found in the "Medical Management Program" section below, along with a discussion of the precertification and other medical management processes.

c. Deductibles and Copayments Payable by Plan Participants

Deductibles/Copayments are dollar amounts that a Covered Person or a Family must pay before the Plan will consider expenses for reimbursement. When there is an In-Network and Out-of-Network deductible, the In-Network deductible accrues toward the Out-of-Network deductible and the Out-of-Network deductible accrues toward the In-Network deductible.

An individual deductible is the amount of covered expenses a Covered Person must pay during each calendar year before the Plan will consider expenses for reimbursement. The Family deductible, if applicable, applies collectively to all Covered Persons in a Family each calendar year. When the Family deductible is satisfied, no further deductible will be applied for any covered Family member during the remainder of that

calendar year. Deductibles do not accrue toward the out-of-pocket maximum.

A copayment (or copay) is an amount that a Covered Person pays to the Covered Person's provider at the time of service. Copayments do not accrue toward the out-of-pocket maximum.

d. Coinsurance Payable by the Plan

Coinsurance is the portion of covered charges payable by the Plan. The Covered Person is responsible for paying the balance of the covered charges not paid by the Plan.

e. Out-of-Pocket Maximums

An out-of-pocket maximum is the maximum amount of covered expenses a Covered Person must pay during a calendar year before the Plan payment percentage increases. The Plan will pay the designated percentage of covered charges until the applicable out-of-pocket maximum is reached, at which time the Plan will pay 100% of the remainder of covered charges for the rest of the calendar year.

When there is an In-Network and Out-of-Network out-of-pocket maximum, the In-Network out-of-pocket maximum accrues toward the Out-of-Network out-of-pocket maximum and the Out-of-Network out-of-pocket maximum accrues toward the In-Network out-of-pocket maximum.

The individual out-of-pocket maximum applies separately to each Covered Person. When a Covered Person reaches the Covered Person's out-of-pocket maximum, the Plan will pay 100% of additional covered expenses for that individual during the remainder of that calendar year.

The Family out-of-pocket maximum applies collectively to all Covered Persons in the same Family. When the Family out-of-pocket maximum is satisfied, the Plan will pay 100% of covered expenses for any Covered Person in the Family during the remainder of that calendar year.

The following expenses do not count toward the out-of-pocket maximum and are never paid at 100%:

- Deductible(s)
- Cost containment penalties
- Copayments
- Excess of Usual and Customary Charges
- Prescription drug copayments

2. Schedule Of Medical Benefits

BENEFIT	PARTICIPATING PROVIDER	OUT-OF-NETWORK/NON-PARTICIPATING PROVIDER
Lifetime Maximum Benefit:	None	
Annual Maximum Benefit:	None	
Participating Provider vs. Non-Participating Provider Benefit Level Covered services rendered by a Participating Provider will be paid at the Participating Provider benefit level. Covered services rendered by a Non-Participating Provider will be paid at the non-Participating Provider benefit level. The Participating Provider benefit level will be paid for Non-Participating Provider services when the charges for those services have been negotiated by Medical Management. All other limitations, requirements and provisions of the Plan will apply, including the Usual and Customary provision of the Plan. The above exception does not apply in the event of consultations and other situations in which the Covered Person and/or the provider selected had the opportunity to select a Participating Provider, and exercised the right to receive services from a Non-Participating Provider. Referrals by a Participating Provider to a Non-Participating Provider will be considered at the Non-Participating Provider benefit level		
Maximums **Note:** The maximums listed below in any one box are the total for Participating and Non-Participating Provider expenses. For example, if a maximum of 60 days is listed in two boxes under a benefit, the calendar year maximum is 60 days total, which may be split between Participating and Non-Participating Providers.		
Deductibles: Individual Family	 $300 $600	 $300 $600
Coinsurance Percentage Rate	90%	70%
Maximum Out-of-Pocket (does not include the deductible): Individual Family	 $650 $1,300	 $3,900 $7,800
Preventive or Routine Care		
Routine Care	After $10 copay, 100% coinsurance; deductible does not apply	Not covered
	Includes routine examinations, routine wellness care, laboratory tests, annual mammogram, pap smear, prostate tests, school/sports physicals, immunizations (including HPV immunizations), and routine colonoscopies.	

BENEFIT	PARTICIPATING PROVIDER	OUT-OF-NETWORK/NON-PARTICIPATING PROVIDER
Routine Mammogram	After $10 copay, 100% coinsurance; deductible does not apply.	Not covered
	Limited to one routine mammogram between the ages of 35 through 39, and one routine mammogram per calendar year age 40 and older.	
COVID-19 Vaccine Administration Costs	100% coinsurance; deductible does not apply	100% coinsurance; deductible does not apply
X-ray & Laboratory Services		
Pre-Admission and Pre-Surgical Testing (prior to surgery or an inpatient Hospital admission)	After deductible is met, 90% coinsurance applies	After deductible is met, 70% of U&C coinsurance applies.
Diagnostic Charges (X-ray and Laboratory)	After deductible is met, 90% coinsurance applies.	After deductible is met, 70% of U&C coinsurance applies.
Hospital Services, Specialized Treatment Facilities and Services		
Inpatient Hospital Services, including Room and Board	$50 copay per confinement, then 90% coinsurance applies; deductible does not apply. Semi-private room rate (private room rate where semi-private room is not available).	$100 copay per confinement, then deductible. After deductible is met, 70% of U&C coinsurance applies. Semi-private room rate (private room rate where semi-private room is not available).
Intensive Care Unit	$50 copay per confinement, then 90% coinsurance; deductible does not apply. ICU/CCU room rate.	$100 copay per confinement, then deductible. After deductible is met, 70% of U&C coinsurance applies. ICU/CCU room rate.
Nursery/Neonatal Intensive Care Unit (facility charges)	$50 copay per confinement, then 90% coinsurance applies; deductible does not apply.	$100 copay per confinement, then deductible. After deductible is met, 70% of U&C coinsurance applies.
Outpatient Hospital	$25 copay per visit, then 90% coinsurance; deductible does not apply.	$75 copay per visit, then deductible. After deductible is met, 70% of U&C coinsurance applies.
Birthing Center	After deductible is met, 90% coinsurance applies.	After deductible is met, 70% of U&C coinsurance applies.
Home Health Care	After deductible is met, 90% coinsurance applies.	After deductible is met, 70% of U&C coinsurance applies.
	100-visit calendar year maximum; up to four hours equal one visit. See specific limitations on physical, occupational and speech therapy.	
Hospice Care Inpatient	After deductible is met, 90% coinsurance applies.	After deductible is met, 70% of U&C coinsurance applies.

BENEFIT	PARTICIPATING PROVIDER	OUT-OF-NETWORK/NON-PARTICIPATING PROVIDER
Hospice Care Outpatient	After deductible is met, 90% coinsurance applies.	After deductible is met, 70% of U&C coinsurance applies.
	185-day Lifetime maximum (Network and Out-of-Network combined).	
Hospice Care Bereavement Counseling	After deductible is met, 50% coinsurance applies.	After deductible is met, 50% of U&C coinsurance applies.
	Limited to 15 visits within six months of death (Network and Out-of-Network combined).	
Skilled Nursing Facility, Extended Care Facility and Rehabilitation Facility	After deductible is met, 90% coinsurance applies.	After deductible is met, 70% of U&C coinsurance applies.
	90-day calendar year maximum for the same or related causes.	
Ambulance Service	After deductible is met, 90% coinsurance applies.	After deductible is met, 70% of up to 300% of Medicare Allowable Rate coinsurance applies (U&C does not apply).
Emergency Services	$36 copay per visit, then 90% coinsurance applies.	$36 copay per visit, then 90% coinsurance applies.
	The copay for Emergency Services is waived if the Covered Person is admitted to the Hospital for an Emergency Medical Condition.	
Urgent Care Facility Visit	$10 copay per visit, then 100% coinsurance; deductible does not apply.	After deductible is met, 70% of U&C coinsurance applies.
Other Services during the Urgent Care Visit	After deductible is met, 90% coinsurance applies.	After deductible is met, 70% of U&C coinsurance applies.
Medical and Surgical Physician Services		
Allergy Serum and Injections	After deductible is met, 90% coinsurance applies.	After deductible is met, 70% of U&C coinsurance applies.
Spinal Manipulation/ Chiropractic	After deductible is met, 90% coinsurance applies.	After deductible is met, 70% of U&C coinsurance applies.
	Maximum of 24 visits per calendar year. Coverage is limited to spinal manipulation, diagnostic testing and x-rays.	
Podiatrist – DPM	After deductible is met, 90% coinsurance applies.	After deductible is met, 70% of U&C coinsurance applies.
	Open cutting procedures only. No routine care. No orthotics.	
Private Duty Nursing	After deductible is met, 90% coinsurance applies.	After deductible is met, 70% of U&C coinsurance applies.
Inpatient Physician Visits	After deductible is met, 90% coinsurance applies.	After deductible is met, 70% of U&C coinsurance applies.
Newborn Care (while mother confined for birth)	After deductible is met, 90% coinsurance applies.	After deductible is met, 70% of U&C coinsurance applies.

BENEFIT	PARTICIPATING PROVIDER	OUT-OF-NETWORK/NON-PARTICIPATING PROVIDER
Inpatient Surgery (includes anesthesiologists)	After deductible is met, 90% coinsurance applies.	After deductible is met, 70% of U&C coinsurance applies.
Pregnancy	After deductible is met, 90% coinsurance applies.	After deductible is met, 70% of U&C coinsurance applies.
Organ/Tissue Transplants (no donor charges)	After deductible is met, 90% coinsurance applies.	Not covered.
	See specific list of covered procedures in the "Medical Benefits" section.	
Outpatient Surgery (includes anesthesiologists)	After deductible is met, 90% coinsurance applies.	After deductible is met, 70% of U&C coinsurance applies.
Surgery performed in a Physician's office	After deductible is met, 90% coinsurance applies.	After deductible is met, 70% of U&C coinsurance applies.
Occupational Therapy	After deductible is met, 90% coinsurance applies.	After deductible is met, 70% of U&C coinsurance applies.
	120 visit calendar year maximum for all inpatient and outpatient treatment combined.	
Physical Therapy	After deductible is met, 90% coinsurance applies.	After deductible is met, 70% of U&C coinsurance applies.
	120 visit calendar year maximum for all inpatient and outpatient treatment combined.	
Speech Therapy	After deductible is met, 90% coinsurance applies.	After deductible is met, 70% of U&C coinsurance applies.
	50 visit calendar year maximum.	
Physician's Office/ Home Visits	$10 copay per visit, then 100% coinsurance; deductible does not apply.	After deductible is met, 70% of U&C coinsurance applies.
Other Services during the Visit	After deductible is met, 90% coinsurance applies.	After deductible is met, 70% of U&C coinsurance applies.
Sleep Apnea/ Disorders	After deductible is met, 90% coinsurance applies.	After deductible is met, 70% of U&C coinsurance applies.
	Subject to Medical Management approval.	
Jaw Joint/TMJ	After deductible is met, 90% coinsurance applies.	After deductible is met, 70% of U&C coinsurance applies.
	Coverage is limited to one Medically Necessary surgery (non-surgical treatment is not covered).	
All Other Covered Medical and Surgical Expenses	After deductible is met, 90% coinsurance applies.	After deductible is met, 70% of U&C coinsurance applies.
Durable Medical Equipment, Supplies, Prosthetics and Orthotics		
Durable Medical Equipment	After deductible is met, 90% coinsurance applies.	After deductible is met, 70% of U&C coinsurance applies.

BENEFIT	PARTICIPATING PROVIDER	OUT-OF-NETWORK/NON-PARTICIPATING PROVIDER
Medical Supplies	After deductible is met, 90% coinsurance applies.	After deductible is met, 70% of U&C coinsurance applies.
Prosthetics and Orthotics (other than foot orthotics)	After deductible is met, 90% coinsurance applies.	After deductible is met, 70% of U&C coinsurance applies.
	Initial only; no replacement	
Mental Disorder and Substance Use Disorder Services		
Inpatient treatment	$50 copay per confinement, then 90% coinsurance; deductible does not apply.	$100 copay per confinement, then deductible. After deductible is met, 70% of U&C coinsurance applies.
	Semi-private room rate (private room rate where semi-private room is not available).	
Outpatient treatment: Office visit	$10 copay per visit, then 100% coinsurance; deductible does not apply.	After deductible is met, 70% of U&C coinsurance applies.
Outpatient (all other items and services)	$25 copay per visit, then 90% coinsurance; deductible does not apply.	$75 copay per visit, then deductible. After deductible is met, 70% of U&C coinsurance applies.
Applied Behavioral Analysis Therapy	After deductible is met, 90% coinsurance applies.	After deductible is met, 70% of U&C coinsurance applies.
	120 visit calendar year maximum for all inpatient and outpatient treatment combined.	

NOTE: Effective March 1, 2020 and until such time as determined by the Trustees in accordance with applicable law, COVID-19 testing performed by PPO and Out-of-Network providers shall be covered at 100% with no co-pay and no deductible as long as such testing is:

- Medically Necessary,
- consistent with guidelines established by the Centers for Disease Control and Prevention (CDC), and
- not covered by the CDC or a state program or agency.

In addition, the cost of the initial Physician's office, emergency room or Urgent Care Facility visit that results in an order for testing for COVID-19 shall be covered at 100% with no co-pay and no deductible. Treatment for COVID-19 will remain at the normal Plan benefit as stated herein.

NOTE: Effective January 15, 2022 and through the end of the COVID-19 Public Health Emergency as declared by the U.S. Department of Health and Human Services, the Plan will reimburse a Covered Person for the cost of up to eight over-the-counter COVID tests per 30-day period. In order to receive

reimbursement, the Covered Person must submit such documentation as required by the Trustees. COVID tests purchased for employment purposes are not eligible for reimbursement.

3. Schedule Of Prescription Drug Benefits

BENEFIT DESCRIPTION	
Retail Pharmacy Option (31-day supply)	**Copayment**
Generic drugs	$10
Formulary Brand Name drugs	$25
Non-Formulary Brand Name drugs	$45
	Prescription drug is covered at 100% after copayment.
Retail or Mail Order Maintenance Drugs (90-day supply)	**Copayment**
Generic drugs	$20
Formulary Brand Name drugs	$40
Non-Formulary Brand Name drugs	$70
	Prescription drug is covered at 100% after copayment.
Specialty Drugs Specialty drugs MUST be obtained directly from the Specialty Pharmacy Program after the prescription has been filled once at a retail Pharmacy	

Details regarding Prescription Drug Benefits are in the "Prescription Drug Benefits" section.

4. Schedule Of Short-Term Disability Benefits

BENEFIT DESCRIPTION	BENEFIT
Weekly benefit limit	$300 per week*
Benefits Begin: For Injury: 1st day of Injury For Illness: 8th day following the Illness For Hospitalization: 1st day of Illness/Injury	
Maximum benefit period payable	26 weeks

* An Employee's weekly benefit will not exceed two-thirds of an Employee's weekly earnings, minus the total amount of benefits, if any, the Employee receives or is entitled to receive for the same period of time from federal Social Security disability benefits to which the Employee is entitled on the date weekly benefits commence.

Details regarding Short Term Disability benefits are in the "Short Term Disability Benefits" section.

SECTION D. DEFINED TERMS

The following terms, when capitalized in the Plan, have the special meanings indicated.

1. **Ambulatory Surgical Center** is licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by Registered Nurses (R.N.) and does not provide for overnight stays.

2. **Ancillary Services:**

   a. Services and supplies related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a Physician or non-Physician practitioner;

   b. Services and supplies provided by assistant surgeons, hospitalists and intensivists;

   c. Diagnostic services, including radiology and laboratory services; and

   d. Services and supplies provided by an Out-of-Network Provider if there is no Participating Provider who can furnish such item or service at such facility.

3. **Assistant Surgeon** is a Physician who actively assists a Physician in charge of a case in performing a surgical procedure. Depending on the type of surgery to be performed, an operating surgeon may have one or two Assistant Surgeons. The need for an Assistant Surgeon is dictated by the technical aspects of the surgery involved.

4. **Birthing Center** means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where birth occurs in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

   The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; and care under the full-time supervision of a Physician and either a Registered Nurse (R.N.) or a licensed nurse-midwife. In addition, the Birthing Center must have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

5. **Brand Name** means a trade name medication.

6. **Calendar Year** means January 1st through December 31st of the same year.

7. **Complications of Pregnancy** means condition(s) (when the Pregnancy is not terminated) whose diagnosis is distinct from Pregnancy but which is adversely affected by Pregnancy or caused by Pregnancy, such as, acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity. Complications of Pregnancy also include an ectopic Pregnancy which is terminated, spontaneous termination of Pregnancy which occurs during a period of gestation when a viable birth is not possible, pernicious vomiting (hyperemesis gravidarum), and toxemia with convulsions (eclampsia of Pregnancy).

   Complications of Pregnancy do not include false labor, occasional spotting, Physician prescribed rest during the period of Pregnancy, morning sickness and similar conditions, which, although associated with the management of a difficult Pregnancy, are not medically classified as distinct Complications of Pregnancy.

8. **Continuing Care Patient**: An individual who, with respect to a provider or facility is:

   a. Undergoing a course of treatment for a serious and complex condition from the provider or facility;

   b. Undergoing a course of institutional or inpatient care from the provider or facility;

   c. Scheduled to undergo non-elective surgery from the provider, including receipt of post-operative care from such provider or facility with respect to such surgery;

   d. Pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

   e. Determined to be terminally ill (as determined under Section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

9. **Cosmetic** means care and treatment performed primarily to improve one's appearance, and does not promote the proper function of the body or prevent or treat an Illness, Injury or disease.

10. **Covered Person** is an Employee, Retiree or Dependent who is covered under the Plan.

11. **Custodial Care** is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Custodial Care includes, but is not limited to, help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

12. **Dependent** is the Spouse or Dependent Child of an Employee or Retiree.

13. **Dependent Child** is defined in the "Eligibility and Commencement of Coverage" section of this document.

14. **Diagnostic Charges** means charges for x-ray or laboratory examinations made or ordered by a Physician in order to detect a medical condition.

15. **Disability** or **Disabled** means the complete inability to perform any and every duty of his or her occupation or of a similar occupation, for which the person is reasonably capable due to education and training, as a result of Illness or Injury. Disability will be determined by the attending Physician.

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

17. **Emergency Medical Condition:** A medical condition, including a mental health condition or substance abuse disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate health attention to result in serious jeopardy to the health of the individual (or for a pregnant individual, the health of the unborn child), serious impairment to bodily functions or serious dysfunction of any bodily organ or part. The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as an Emergency Medical Condition.

18. **Emergency Services:** With respect to an Emergency Medical Condition:

    a. An appropriate medical screening examination that is within the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including Ancillary Services routinely available in the Emergency Department to evaluate the Emergency Medical Condition, along with additional medical

examination and treatment to the extent they are within the capabilities of the staff and facilities available to the Hospital or Freestanding Emergency Department to stabilize the patient;

b. Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished); and

c. With respect to Non-Network Providers and facilities, post-stabilization services until the patient is determined by the provider or facility to be able to travel using non-medical transportation to non-emergency medical transportation. At such time, the patient may give informed consent to continued treatment by the Non-Network Provider which treatment shall not be considered Emergency Services. Such consent must acknowledge that the patient understands that continued treatment by the Non-Network Provider may result in greater cost to the patient and may only be given after the patient is provided with a written notice, as required by federal law, stating

   (1) that the provider is a Non-Network Provider with respect to the Plan,

   (2) the estimated charges for treatment and any advance limitations that the Plan may apply to treatment,

   (3) the names of any Participating Providers at the facility who are able to treat the patient, and

   (4) that the patient may elect to be referred to one of the Participating Providers listed.

19. Employee is an employee who is on the regular payroll of an Employer and who is performing the duties of his or her job with the Employer in an employee/employer relationship on a full-time basis, as determined by the Employer.

20. Employer is any Employer who has an obligation under a collective bargaining agreement to contribute to the Sheet Metal Workers Local Union 268 Welfare Fund (the "Fund") on behalf of covered Employees and eligible Dependents. Employer also means Sheet Metal Workers Local 268, one of the fringe benefit funds administered by Sheet Metal Workers Local 268, and any other employer in a position related to the sheet metal industry that is not covered by a collective bargaining agreement with Sheet Metal Workers

Local 268 or any other union and elects to participate in this Plan and contribute to the Fund with the consent of the Plan Sponsor.

21. **Enrollment Date** is the first day of coverage or, if there is a waiting period, the first day of the waiting period.

22. **ERISA** is the Employee Retirement Income Security Act of 1974.

23. **Experimental** or **Investigational** means services, supplies, care and treatment which do not constitute accepted and appropriate medical practice considering the facts and circumstances of the case and by the generally accepted standards of a reasonably substantial, qualified, responsible, relevant segment of the appropriate medical community or government oversight agencies at the time services were rendered, as determined by the Plan Administrator as set forth below.

    The Plan Administrator must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The Plan Administrator shall 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 decision of the Administrator will be final and binding on the Plan. In addition to the above, the Plan Administrator will be guided by the following principles to determine whether a proposed treatment is deemed to be Experimental or Investigational:

    a. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished, then it is deemed to be Experimental or Investigational; or

    b. If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law required such review or approval, then it is deemed to be Experimental or Investigational; or

    c. If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinical trials, or is the subject of the research, experimental, study, investigational or other arm of ongoing 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, then it is deemed to be Experimental or Investigational; or

d. If 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 as compared with a standard means of treatment or diagnosis, then it is deemed to be Experimental or Investigational.

   Reliable Evidence shall mean: 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, service, 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.

Drugs are considered Experimental if they are not commercially available for purchase or they are not approved by the FDA for general use.

Expenses related to Off-Label Drug Use (the use of a drug for a purpose other than that for which it was approved by the FDA) will be eligible for coverage when all of the following criteria have been satisfied:

a. The named drug is not specifically excluded under the General Limitations of the Plan; and

b. The named drug has been approved by the FDA; and

c. The Off-Label Drug Use is appropriate and generally accepted by the medical community for the condition being treated; and

d. If the drug is used for the treatment of cancer, the American Hospital Formulary Service Drug Information or the NCCN Drugs and Biologics Compendia recognize it as an appropriate treatment for that form of cancer.

Expenses for drugs, devices, services, medical treatments or procedures related to an Experimental or Investigational treatment ("Related Services") and complications from an Experimental or Investigational treatment and their Related Services are excluded from coverage, even if such complications and Related Services would be covered in the absence of the Experimental or Investigational treatment.

Final determination of Experimental or Investigational, Medical Necessity or whether a proposed drug, device, medical treatment or procedure is covered under the Plan will be made by and in the sole discretion of the Plan Administrator.

24. **Family** is an Employee who is a Covered Person or Retiree who is a Covered Person and his or her Dependents who are Covered Persons.

25. **Formulary** means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by the Plan.

26. **Fund** means the Sheet Metal Workers Local No. 268 Welfare Trust Fund.

27. **Generic Drug** means a Prescription Drug which has the equivalency of a brand name drug with the same use and metabolic disintegration.

28. **Genetic Information** means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes. Genetic Information will not be taken into account for purposes of

    a. Determining eligibility for benefits under the Plan (including initial enrollment and continued eligibility), and

    b. Establishing contribution or premium accounts for coverage under the Plan.

29. **Home Health Care Agency** is an organization that provides Home Health Care Services and Supplies, is federally certified as a Home Health Care Agency, and is licensed by the state in which it is located, if licensing is required.

30. **Home Health Care Services and Supplies** include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (not including general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

31. **Hospice Agency** is a public or private organization, licensed and operated according to the law, primarily engaged in providing Hospice Care Services and Supplies for palliative, supportive, and other related care for a Covered

Person diagnosed as terminally ill with a medical prognosis that life expectancy is six months or less.

32. **Hospice Care Plan** is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

33. **Hospice Care Services and Supplies** are those provided through a Hospice Agency and under a Hospice Care Plan, and include inpatient care in a Hospice unit or other licensed facility, home care, and Family counseling during the bereavement period.

34. **Hospice Unit** is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

35. **Hospital** is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these requirements: accredited as a Hospital by the Joint Commission on Accreditation Program; approved by Medicare as a Hospital; maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (RN's); and operated continuously with organized facilities for operative surgery on the premises.

    "Hospital" also includes:

    - A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

    - A facility operating primarily for the treatment of Substance Use Disorders if it meets the following requirements: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour-a-day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Use Disorders.

36. **Hour of Covered Service** means an hour of covered employment actually worked by a Bargained Employee that applies towards eligibility for coverage under the Plan.

37. **Illness** means a non-occupational bodily disorder, disease, physical sickness, Pregnancy, childbirth, miscarriage, Complications of Pregnancy, Mental Disorders or Substance Use Disorders.

38. **Independent Freestanding Emergency Department:** A public or private facility, licensed and operated according to the law, which is geographically separate and distinct from a Hospital under applicable state law and provides emergency services.

39. **Infertility** means incapable of producing offspring.

40. **Injury** means a non-occupational accidental physical injury caused by an unexpected external means.

41. **Intensive Care Unit** is defined as a separate, clearly designated service area, which is maintained within a Hospital solely for the care and treatment of patients who are critically ill and which has facilities for special nursing care not available in regular rooms and wards of the Hospital; special life-saving equipment which is immediately available at all times, at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

42. **Late Enrollee** means a Covered Person who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

43. **Lifetime** is used in the Plan in reference to benefit maximums and limitations and is understood to mean while a Covered Person is covered under the Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

44. **Medical Care Facility** means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

45. **Medically Necessary** or **Medical Necessity** means the treatment is generally accepted by medical professionals in the United States as proven, effective and appropriate for the condition based on recognized standards of the health care specialty involved.

    "Proven" means the care is not considered Experimental or Investigational, meets a particular standard of care accepted by the medical community, and is approved by the Food and Drug Administration (FDA) for general use.

    "Effective" means the treatment's beneficial effects can be expected to outweigh any harmful effects. Effective care is treatment proven to have a

positive effect on the Covered Person's health, while addressing particular problems caused by disease, Injury, Illness or a clinical condition.

"Appropriate" means the treatment's timing and setting are proper and cost effective.

Medical treatments which are not proven, effective and appropriate are not covered by the Sheet Metal Workers Local Union 268 Welfare Plan.

All criteria must be satisfied. When a Physician recommends or approves certain care, it does not mean that care is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether the care or treatment is Medically Necessary.

46. Medicare is the Health Insurance For The Aged Disabled program under Title XVIII of the Social Security Act, as amended.

47. Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services.

48. Morbid Obesity is defined as:

a. A body mass index (BMI) of 40 or greater, or

b. A BMI of 35 or greater in conjunction with a severe co-morbidity, such as obesity hypoventilation, sleep apnea, diabetes, hypertension, cardiomyopathy, or musculoskeletal dysfunction.

49. Non-Participating Provider or **Out-of-Network Provider** means a Hospital, Physician or other health care provider that has not entered into a contractual agreement with the Plan's Preferred Provider Organization.

50. Outpatient Care or **Outpatient Services** is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a Covered Person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

51. Participating Provider or **In-Network Provider** means a Hospital, Physician or other health care provider that has a contractual agreement with the Plan's Preferred Provider Organization.

52. Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where the pharmacist practices.

53. **Physician** means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D. or Psy.D.), Speech Language Pathologist, and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

54. **Plan** means Sheet Metal Workers Local Union 268 Welfare Plan.

55. **Plan Administrator** is the Board of Trustees of the Sheet Metal Workers Local Union 268 Welfare Plan, as further identified under the General Plan Information section.

56. **Plan Participant** is any Employee, Retiree or Dependent who is covered under the Plan.

57. **Plan Sponsor** is the Board of Trustees of the Sheet Metal Workers Local Union 268 Welfare Plan, as further identified under the General Plan Information section.

58. **Plan Year** is the 12-month period beginning July 1 and ending June 30.

59. **Preventive** or **Routine Care** means well adult and well childcare by a Physician that is not for an Illness or Injury.

60. **Pregnancy** is childbirth and conditions associated with Pregnancy, including Complications of Pregnancy.

61. **Prescription Drug** means any of the following when dispensed upon a written prescription of a licensed Physician: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend, "Caution: federal law prohibits dispensing without prescription;" injectable insulin; hypodermic needles or syringes. Such drug must be Medically Necessary in the treatment of an Illness or Injury.

62. **Qualified Medical Child Support Order (QMCSO)** is a judgment or decree by a court of competent jurisdiction or order issued through an administrative process established under state law that has the force and effect of state law that requires the Plan to provide coverage to the children of an Employee pursuant to a state domestic relations law.

    A medical child support order must meet certain requirements specified in ERISA in order to be considered "qualified."

63. **Qualifying Payment Amount:** The amount calculated using the methodology described in 29 CFR 2590.716-6(c) which is generally the contracted rates of the Plan for the service or supply in the geographic region, with certain exceptions.

64. **Recognized Amount:** For services or supplies furnished by a Non-Network Provider:

    a. An amount determined by an applicable All-Payer Model Agreement;

    b. If there is not applicable All-Payer Model Agreement, an amount determined by a specified state law; or

    c. If there is no applicable All-Payer Model Agreement or specified state law, the lesser of the amount billed by the Provider or facility or the Qualifying Payment Amount.

    For air ambulance services (if covered by the Plan), the lesser of the amount billed by the Provider or facility or the Qualifying Payment Amount.

65. **Retiree** is a former Employee of an Employer who retired from employment with the Employer.

66. **Skilled Nursing Facility**, including an extended care facility and a rehabilitation facility, is a facility that fully meets all of the following:

    a. It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Illness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (LPN) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

    b. Its services are provided for compensation and under the full-time supervision of a Physician.

    c. It provides 24-hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

    d. It maintains a complete medical record on each patient.

    e. It has an effective utilization review plan.

    f. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally challenged, Custodial Care or educational care or care of Mental Disorders.

    g. It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

67. **Spinal Manipulation/Chiropractic Care** means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to distortion, misalignment or subluxation of, or in, the vertebral column.

68. **Spouse** is defined in the "Eligibility and Commencement of Coverage" section of this document.

69. **Substance Use Disorder** means any disease or condition that is classified as a substance use disorder in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services.

70. **Temporomandibular Joint (TMJ)** syndrome is the treatment of jaw joint disorders including conditions of structures linking the jawbone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to, orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

71. **Urgent Care Facility** is a public or private facility, licensed and operated according to the law, which provides immediate care. Treatment must be administered under the supervision of a recognized Physician or nurse as defined in the Plan and the facility must maintain a relationship with an available pool of specialists for consultation and treatment when necessary.

72. **Usual and Customary Charge (U&C)** is a charge which is not more than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of that care or supply in the same area, as determined by the Plan Administrator. The nature and severity of the condition being treated will be considered. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

    If the actual charge billed is less than the Usual and Customary Charge as defined above, the lesser charge billed will be deemed to be the Usual and Customary Charge.

    The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Customary.

SECTION E. ELIGIBILITY AND COMMENCEMENT OF COVERAGE

1. Eligibility

a. Eligible Classes of Employees

All Employees must meet the eligibility requirements established by the Trustees. Classification of Employees is as follows:

(1) Bargained Employees;

(2) Non-Bargained Employees; and

(3) Retirees.

b. Eligibility Rules for Bargained Employees

In order to become eligible for participation in the Plan, a Bargained Employee must:

(1) Be a member of a bargaining unit represented by Sheet Metal Workers Local 268 and employed by an Employer who is obligated pursuant to a collective bargaining agreement with Sheet Metal Workers Local 268 to make contributions on the Bargained Employee's behalf to the Fund; and

(2) Complete 350 Hours of Covered Service with an Employer during the period of three consecutive calendar months beginning with the month during which the Bargained Employee initially commenced employment covered by the Plan; and

(3) Have the required contributions paid to the Fund by the Employer on behalf of such Bargained Employee. If required contributions are not promptly received from the Employer, the Employee will be given credit for Hours of Covered Service upon the Fund's receipt of verification of hours worked.

In the event a Bargained Employee does not complete 350 Hours of Covered Service in the first three consecutive calendar months following the Bargained Employee's initial commencement of employment covered by the Plan, the Bargained Employee will become eligible after completing 350 Hours of Covered Service in any three consecutive calendar month period of covered employment thereafter.

Once the Bargained Employee meets the eligibility requirement above, coverage under the Plan becomes effective as of the first day of the following calendar month.

c. Eligibility Rules for Non-Bargained Employees

In order to become eligible for participation in the Plan, a Non-Bargained Employee must:

(1) Be employed by Sheet Metal Workers Local 268; OR be employed by one of the fringe benefit funds administered by Sheet Metal Workers Local 268; OR be employed by an Employer in a position related to the sheet metal industry and not be covered by a collective bargaining agreement with Sheet Metal Workers Local 268 or any other union. For purposes of this paragraph, the term "related to" is intended to mean individuals for whom significant portions of their duties involve the sheet metal industry. Examples of employees who would be considered "related to" the sheet metal industry include estimators, project managers, bookkeepers, clerical, secretarial, and similar office employees and officers, if the business itself or the duties of that particular employee concern the sheet metal industry. Final determination of eligibility under this paragraph shall be determined by the Plan Administrator; and

(2) Be employed by the Employee's Employer an average of 20 or more hours per week; and

(3) The plan must receive two (2) consecutive months of contributions by the employer.

Once you meet the eligibility requirements above, coverage under the Plan becomes effective on the first day of the following month.

d. Eligibility Rules for Retirees

The Retiree plan is a continuation of the regular Plan of health benefits through the self-payment provisions of the Plan. The Plan is available for eligible Non-Medicare eligible Retirees and their eligible Dependents. Once a Retiree becomes eligible for Medicare, coverage will be provided through an insured Medicare Supplement or Medicare Advantage Plan.

A Retiree is eligible for the Plan if the Retiree meets all of the following:

(1) The Retiree has had at least five (5) consecutive years of coverage under the Sheet Metal Workers Local Union 268 Welfare Plan; and

(2) The Retiree meets one of the following requirements:

(a) the Retiree qualifies for a pension benefit under the Sheet Metal Workers International Association Local Union 268 Pension Trust and Plan approved by the Plan Administrator; or

(b) the Retiree has had at least ten (10) consecutive years of coverage under the Sheet Metal Workers Local Union 268 Welfare Plan;

(3) The Retiree is eligible and participating under the Sheet Metal Workers Local Union 268 Welfare Plan one day prior to the earliest of:

(a) the date the Retiree becomes permanently and totally disabled as determined by the Social Security Administration; or

(b) for those electing coverage on or after May 1, 2018, the date the Retiree leaves covered employment after the Retiree reaches age 60; or

(c) the Retiree's annuity starting date under an approved pension plan; and

(4) The Retiree continues to pay the self-payment contribution required by the Plan to continue coverage.

If a covered Retiree obtains subsequent employment and becomes covered under another employer-sponsored health plan, coverage under this Plan will terminate.

e. Eligibility Rules for Dependents – All Classes

An eligible Dependent is any one of the following persons:

(1) A covered Employee's or covered Retiree's Spouse, unless legally separated.

(2) The Spouse or Dependent Child of a covered Employee or Retiree as of the date of the Employee's or Retiree's death, as long as the Dependent remains eligible to participate in the Plan under these Eligibility Rules and continues to pay the self-payment contribution required by the Plan to continue coverage. The Plan Administrator will set the amount of the required contribution.

(3) A covered Employee's or Retiree's Dependent child until the end of the month in which the Dependent Child attains age 26.

(4) A covered Employee's or Retiree's Dependent child who is unmarried and physically or mentally incapable of self-support upon attaining age 26, subject to the Employee or Retiree continuing to meet the Plan eligibility requirements. The Plan Administrator may request proof of the Dependent child's incapacity from time to time, but not before the 60-day period preceding the date the coverage would normally terminate. If proof is requested but not received by the Plan Administrator within 60 days, the Dependent Child will not be considered an eligible Dependent beyond the 60-day period even though still incapacitated.

(5) A Dependent Child for whom the covered Employee is required to provide health coverage due to a Qualified Medical Child Support Order (QMCSO). Procedures for determining a QMCSO) may be obtained from the Plan Administrator at no cost.

The term "Spouse" means the person to whom a covered Employee or Retiree is lawfully married, including individuals married to a person of the same sex. The term "Spouse" does not include domestic partners or individuals in civil unions. The Plan Administrator may require documentation proving a legal marital relationship.

The term "Dependent Child" shall mean a covered Employee's or Retiree's (a) natural born child, (b) stepchild (defined as the natural or adopted child of the Employee's or Retiree's Spouse), (c) legally adopted child (or a child placed with the covered Employee or Retiree in anticipation of adoption), or (d) a child for whom a covered Employee or Retiree is appointed legal guardian, or has been awarded primary custody by a court.

A child under age 19 not otherwise meeting the definition of "Dependent Child" may be eligible for dependent coverage if: (a) such child's primary residence is with a covered Employee or Retiree; and (b) the Plan Administrator is presented evidence which the Plan Administrator deems acceptable that the Employee or Retiree has primary responsibility to care for the child. Upon reaching the age of 19 while covered under the Plan, such a child will continue to be eligible for coverage under the Plan on a self-payment basis at the rate of $75 per month until the covered child reaches age 26. The Plan Administrator may change the self-payment contribution rate at any time by giving written notice of the new rate to all Plan Participants. Failure to pay a month's self-payment contribution will result in loss of coverage for such a child, and once coverage is lost, such coverage cannot be reinstated.

The Plan Administrator may require documentation proving dependency, including birth certificates or initiation of legal proceedings severing parental rights.

The following are excluded as eligible Dependents: any Spouse who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee or Retiree.

If a person covered under the Plan changes status from Employee or Retiree to Dependent or Dependent to Employee, and the person is covered continuously under the Plan, during and after the change in status, credit will be given toward deductibles and all amounts applied to Plan maximums.

If both mother and father are covered Employees or Retirees of an Employer, their children will be covered as Dependents of the mother or father, but not of both.

The covered Employee or Retiree shall notify the Plan Administrator when the Employee or Retiree believes a new Dependent is entitled to coverage.

2. Effective Date Of Coverage

a. Bargained and Non-Bargained Employees

Entry date into the Plan shall be on the first day of the next month following fulfillment of eligibility requirements, subject to the following. When the Fund Office determines that an individual has fulfilled the eligibility requirements, the Fund Office will deliver to the individual an enrollment card, using a method of delivery that will require signed acknowledgement of receipt. That card will contain the following language:

> "FAILURE TO COMPLETE and RETURN THIS ENROLLMENT CARD TO THE FUND OFFICE WITHIN SIXTY (60) DAYS OF THE DAY ON WHICH YOU RECEIVED IT WILL RESULT IN DEFERRING THE EFFECTIVE DATE OF YOUR COVERAGE UNTIL THE DATE ON WHICH THE COMPLETED ENROLLMENT CARD IS RECEIVED BY THE FUND OFFICE."

If the individual fails to sign the acknowledgement of receipt of the Enrollment Card for a period of sixty (60) days from the date it was mailed OR fails to return the completed Enrollment Card within sixty (60) days of the date on which the individual received the Enrollment Card,

coverage will not become effective until the completed Enrollment Card is received in the Fund Office.

b. Dependent Coverage (Bargained and Non-Bargained Employees)

The effective date of coverage will be the first day the Employee has qualified for benefits or, if later, the first day the Dependent meets the eligibility requirements for Dependent coverage while the Employee is qualified for benefits.

c. Retirees

The effective date of coverage will be the first day the Retiree has met the eligibility requirements for Retiree coverage and makes the required payment.

d. Dependent Coverage (Retirees)

The effective date of coverage will be the first day the Retiree has met the eligibility requirements for Retiree coverage or, if later, the first day the Dependent meets the eligibility requirements for Dependent coverage while the Retiree is qualified for benefits, and makes the required payment.

3. Enrollment

a. Enrollment Requirements

An Employee or Retiree must enroll for coverage by filling out and signing an enrollment application. As part of the enrollment requirements an Employee will be required to provide his or her Social Security number, as well as the Social Security numbers of his or her Spouse and any Dependent Children. The Plan Administrator may request this information at any time for continued eligibility under the Plan. Failure to provide the required Social Security numbers may result in loss of eligibility or loss of continued eligibility under the Plan.

b. Enrollment Requirements for Newborn Children

A newborn child must be enrolled as a Dependent under the Plan within 31 days of the child's birth in order for coverage to take effect from the date of birth. If a child is enrolled as a Dependent more than 31 days after the child's birth, the child's coverage will become effective as of the date the child is enrolled in the Plan.

4. Special Enrollment/Status Change

The Plan provides an Employee or Retiree and his or her eligible Dependents the opportunity to enroll in the Plan during a special enrollment period, provided certain special enrollment/status change events occur. The special enrollment/status change events that occur resulting in a special enrollment period under the Plan are more fully described below. With respect to the special enrollment events below, any Employee or Retiree who has a special enrollment right may elect coverage (for such Employee or Retiree and his or her eligible Dependents) under any Plan option that is available to an Employee or Retiree during an initial or annual re-enrollment opportunity, as long as the Employee or Retiree (or Dependent) is otherwise eligible for that Plan option.

a. Special Enrollment Events

(1) Special Enrollment Rights because of loss of other coverage.

If an Employee or Dependent is eligible for coverage under the Plan but chose not to enroll in the Plan because the Employee was covered under group health plan or group health insurance coverage at the time that coverage under the Plan was offered, the Employee or Dependent may enroll later if one of the following conditions is met:

(a) The other coverage was not COBRA coverage and that coverage terminates because of a Loss of Eligibility (as described below);

(b) The other coverage was not COBRA coverage and an employer's contributions towards the coverage cease; or

(c) The coverage of the Employee or Dependent was under COBRA and the COBRA coverage ends because of Exhaustion of COBRA coverage (as described below).

It is important to note that when an Employee or Dependent loses coverage due to one of the above events, both the Employee and Dependent may special enroll.

A "Loss of Eligibility" includes a loss of eligibility because of legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, a reduction in the number of hours of employment, or the individual's prior plan no longer offers any benefits to the class of similarly situated persons that includes the individual. A Loss of Eligibility also occurs if the other

coverage is provided through an HMO or another arrangement that does not provide benefits to individuals who no longer reside or work in a service area, if the Employee or Dependent no longer resides or works in the applicable service area (unless the HMO or other arrangement is part of group plan that makes another benefit option available to the affected Employee or Dependent).

"Exhaustion of COBRA coverage" occurs when COBRA coverage ceases for any reason other than a failure of the Employee or Dependent to pay premiums on a timely basis or for cause.

The Plan Administrator may require the Employee to state in writing at the time coverage is offered that other health coverage was the reason for declining enrollment in the Plan (for the Employee or a Dependent). If the Plan Administrator imposes such a requirement and informs the Employee of the requirement, the Employee or Dependent will not be eligible for special enrollment based on the loss of coverage unless the employee provided the required statement at the time coverage was declined.

The Employee or Dependent must request enrollment in the Plan during the Special Enrollment period, which ends 31 days after (a) the other coverage terminates, (b) an employer's contributions cease, or (c) COBRA coverage is exhausted, whichever applies. Coverage will be effective no later than the first day of the first month that begins after the Plan Administrator receives a completed request for enrollment.

An individual does not have a special enrollment right if the Employee or Dependent loses other coverage because of a failure to pay premiums or required contributions or if the coverage is terminated for cause (such as for making a fraudulent claim).

(2) Special Enrollment Rights because of marriage, birth or adoption.

(a) An otherwise eligible Employee (i.e., an Employee who is not a current Plan Participant but who has completed any waiting period and any other eligibility requirements under the Plan) may enroll himself or herself in the Plan during the special enrollment period described below if an individual becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption.

(b) A covered Employee may enroll an individual who becomes the Employee's spouse during the special enrollment period described below if either: (1) the individual becomes the covered Employee's Spouse; or (2) the individual is the covered Employee's Spouse and a child becomes a Dependent of the covered Employee through birth, adoption or placement for adoption.

(c) An eligible Employee and an individual who becomes the Employee's Spouse may enroll in the Plan during the special enrollment period described below if: (1) the Employee and the individual become married, or (2) the Employee and the individual already are married and a child becomes a Dependent of the Employee through birth, adoption or placement for adoption.

(d) A covered Employee may enroll an individual in the Plan during the special enrollment period described below if the individual becomes a Dependent of the covered Employee through marriage, birth, adoption or placement for adoption.

(e) An eligible Employee may elect to enroll the Employee and an individual who becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption.

The special enrollment period is a period of 31 days that begins on the date of the marriage, birth, adoption or placement for adoption.

Coverage for an eligible Employee or Dependent who enrolls in the Plan because of a marriage, birth or adoption special enrollment right will be effective:

(f) In the case of marriage, on the date of marriage if the Plan Administrator receives a completed request for enrollment electing coverage for the Employee or Dependent and if the completed request for enrollment is submitted within 31 days after the marriage;

(g) In the case of a Dependent's birth, on the date of birth if the completed request for enrollment is submitted within 31 days of the birth; or

(h) In the case of a Dependent's adoption or placement for adoption, on the date of the adoption or placement for adoption if the completed request for enrollment is submitted

within 31 days of the date of the adoption or placement for adoption.

(3) Special Enrollment due to coverage under Medicaid or under a State Children's Health Insurance Program (SCHIP).

If an eligible Employee, Retiree or Dependent did not enroll in the Plan when initially eligible, but otherwise eligible to enroll, the eligible Employee, Retiree and Dependent will be permitted to later enroll in the Plan under one of the following circumstances:

(a) The eligible Employee, Retiree or Dependent was covered under Medicaid or SCHIP at the time of initial enrollment and such coverage subsequently terminates; or

(b) The eligible Employee, Retiree or Dependent becomes eligible for a premium assistance subsidy under Medicaid or SCHIP subsequent to the time they were initially eligible.

The eligible Employee, Retiree or Dependent must notify the Plan of the event within 60 days after coverage under Medicaid or SCHIP terminates or within 60 days after the Employee's, Retiree's or Dependent's eligibility for a premium assistance subsidy under Medicaid or SCHIP is determined, whichever is applicable. The Employee, Retiree or Dependent then has 31 days to provide proof of eligibility and enroll in the Plan.

SECTION F. TERMINATION OF COVERAGE

1. Bargained Employees

A covered Bargained Employee's coverage will immediately terminate on the earliest of:

a. The date the Plan is terminated; or

b. The date the Bargained Employee withdraws from the Sheet Metal Workers International Association Local 268; or

c. The date the Employer no longer makes a contribution to the Fund; or

d. The first day of any month of any year in which either:

(5) The Bargained Employee failed to complete 1,000 or more Hours of Covered Service in the immediately preceding 12 consecutive month period; or

(6) The Bargained Employee failed to complete 2,500 or more Hours of Covered Service in the immediately preceding 24 consecutive month period, unless the Bargained Employee pays the required contribution necessary to continue benefits in effect from that time until such time as the Bargained Employee is re-qualified. The amount of the required contribution will be in the sole discretion of the Plan Administrator. Once the Bargained Employee's coverage is terminated for failure to meet the requirements set forth in this paragraph, the Bargained Employee must meet the initial eligibility requirements as set out in the section entitled "Eligibility and Commencement of Coverage;"

provided, however, if the Bargained Employee becomes eligible for the Disability Extension of Coverage, the Bargained Employee's eligibility status under the Plan will be frozen and remain frozen until the Bargained Employee is no longer eligible for the Disability Extension of Coverage; or

e. The date the Bargained Employee (or any person seeking coverage on behalf of the Bargained Employee) performs an act, practice or omission that constitutes fraud; or

f. The date the Bargained Employee (or any person seeking coverage on behalf of the Bargained Employee) makes an intentional misrepresentation of a material fact.

2. Non-Bargained Employees

A covered Non-Bargained Employee's coverage will immediately terminate on the earliest of:

a. The date the Plan is terminated; or

b. The date the Employer no longer makes a contribution to the Fund; or

c. The date the Non-Bargained Employee fails to pay any required contribution; or

d. The date the Non-Bargained Employee is no longer employed by the Non-Bargained Employee's Employer an average of 20 hours or more per week; or

e. The first day of the third month following the last month for which a contribution has been received on behalf of the Non-Bargained Employee; or

f. The date the Non-Bargained Employee (or any person seeking coverage on behalf of the Non-Bargained Employee) performs an act, practice or omission that constitutes fraud; or

g. The date the Non-Bargained Employee (or any person seeking coverage on behalf of the Non-Bargained Employee) makes an intentional misrepresentation of a material fact.

3. Retirees

A covered Retiree's coverage will immediately terminate on the earliest of:

a. The date the Plan is terminated; or

b. The date the Retiree fails to pay any required contributions; or

c. The date of the Retiree's death; or

d. The date the Retiree (or any person seeking coverage on behalf of the Retiree) performs an act, practice or omission that constitutes fraud; or

e. The date the Retiree (or any person seeking coverage on behalf of the Retiree) makes an intentional misrepresentation of a material fact.

4. Dependents Of Employees And Retirees

A covered Dependent's coverage will immediately terminate on the earliest of:

a. The date the Dependent ceases to be a Dependent as herein defined; or

b. The date the Employee or Retiree (of whom the Covered Person is a Dependent) ceases to be a Plan Participant; or

c. The date the Plan is terminated; or

d. The date the Dependent (or any person seeking coverage on behalf of the Dependent) performs an act, practice or omission that constitutes fraud; or

e. The date the Dependent (or any person seeking coverage on behalf of the Dependent) makes an intentional misrepresentation of a material fact.

5. Disability Extension of Coverage

In the event a covered Bargained Employee becomes Disabled due to an Injury or Illness covered under workers' compensation or a similar law prior to the time the Employee is no longer eligible for Plan coverage based on hours worked, medical and prescription drug benefits under the Plan will be continued for the Bargained Employee and the Bargained Employee's covered Dependents until the earlier of (a) twelve months following the date of the Injury or Illness that is covered under workers' compensation or similar law, or (b) the date the Bargained Employee's Physician releases the Bargained Employee to return to work.

In order to qualify for the Disability Extension of Coverage, the Bargained Employee's Disability must be under continuous treatment by a Physician. The Plan Administrator reserves the option of requesting periodic physical examinations from either the current Physician on the case or a Physician of the Plan Administrator's choice. Failure to provide requested Physicians' statements will result in termination of benefits. The Bargained Employee is responsible for providing the following information in a clearly understandable format:

a. History regarding when symptoms first appeared or accident happened;

b. Diagnosis;

c. Dates of treatment;

d. Nature of treatment;

e. Progress;

f. Prognosis;

g. Suitability for rehabilitation; and

h. Physician's signature and tax I.D. number.

Additional information may be required based upon the Bargained Employee's Illness or Injury.

6. Continuation During Family And Medical Leave (FMLA)

The Plan shall at all times comply with the Family and Medical Leave Act of 1993, as amended (FMLA), and as promulgated in regulations issued by the Department of Labor.

All paid sick leave time and vacation leave time used as FMLA qualifying leave counts towards the 12 weeks of FMLA qualifying leave.

During any leave taken under the FMLA, the covered Employee may maintain coverage under the Plan on the same conditions as coverage would have been provided if the Employee had been continuously employed during the leave period.

If the covered Employee fails to return to work after the FMLA leave, the Employer has the right to recover its contributions toward the cost of coverage during the FMLA leave.

If coverage under the Plan terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work at the end of the FMLA leave.

7. Re-Establishing Terminated Employee Eligibility

Except as otherwise specified in the Plan, if an Employee whose covered employment is terminated and who no longer meets the Plan's eligibility requirements is subsequently rehired into covered employment, the Employee will be treated as a new hire and will be required to satisfy all eligibility and enrollment requirements of the Plan.

8. Employees On Military Leave

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA). These rights apply only to Employees and their Dependents that were covered under the Plan at the time of leaving for military service.

a. The maximum period of coverage of an Employee and the Employee's Dependents under such an election shall be the lesser of:

   (1) The 24-month period beginning the date on which the Employee's absence begins; or

(2) The period beginning on the day the Employee's military service absence begins and ending on the day after the date on which the Employee returns to employment with the Employer or fails to apply for or return to a position of employment with the Employer within the time limit that applies under USERRA.

b. An Employee who elects to continue Plan coverage may be required to pay up to 102% of the full contribution under the Plan, except an Employee on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

c. Continuation coverage provided under USERRA counts as COBRA continuation coverage as long as the notice requirements of COBRA are satisfied in connection with the USERRA leave.

d. An Employee returning from USERRA-covered military leave who participated in the Plan immediately before going on USERRA leave has the right to resume coverage under the Plan upon return from USERRA leave, as long as the Employee resumes employment within the time limit that applies under USERRA. No waiting period will apply to an Employee returning from USERRA leave (within the applicable time period) unless the waiting period would have applied to the Employee if the Employee had remained continuously employed during the period of military leave.

9. Retroactive Termination Of Coverage

Except in cases where a Covered Person fails to pay any required contribution to the cost of coverage, the Plan will not retroactively terminate coverage under the Plan for any Covered Person unless the Covered Person (or a person seeking coverage on behalf of that Covered Person) performs an act, practice or omission that constitutes fraud with respect to the Plan, or unless the individual makes an intentional misrepresentation of material fact. In such cases of fraud or misrepresentation, the Plan will provide at least thirty days advance written notice to each Covered Person who would be affected before coverage will be retroactively terminated. As provided above, coverage may be retroactively terminated in cases where required Covered Person contributions have not been paid by the applicable deadline. In those cases, no advance written notice is required.

SECTION G. COBRA CONTINUATION COVERAGE

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), provides to covered Employees and their covered Spouses and Dependent children the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances where coverage under a group health plan would otherwise end. This Section is intended to inform you, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in regulations issued by the Department of the Treasury and the Department of Labor. This Section is intended to reflect the law and does not grant or take away any rights that apply under applicable law. Instructions on COBRA rights and procedures, as well as election forms and other information, will be provided by the Plan Administrator to Covered Persons who become Qualified Beneficiaries under COBRA.

1. What Is COBRA Continuation Coverage

COBRA continuation coverage is group health plan coverage that the Plan must offer to certain Employees, Retirees and their eligible Family members (called "Qualified Beneficiaries") at specific rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of one of certain enumerated events that result in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The continuation coverage is identical to the coverage under the Plan that the Qualified Beneficiary had immediately before the Qualifying Event, or, if the coverage has been changed, the coverage is identical to the coverage provided to similarly situated Employees who have not experienced a Qualifying Event.

2. Options Other Than COBRA

If you become eligible for COBRA continuation coverage, you will receive a Notice from the Plan explaining your election options. It is important that you read this Notice in order to make an informed decision regarding your health care coverage options.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special

enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if the Plan generally does not accept late enrollments. Other options may be available to you through Medicare, Medicaid, or the Children's Health Insurance Program (CHIP). You can learn more about many of these options at www.healthcare.gov.

3. Who Is A Qualified Beneficiary

In general, a Qualified Beneficiary is:

a. Any individual who, on the day before a Qualifying Event, is covered under the Plan as either a covered Employee, the Spouse of a covered Employee, or a Dependent Child of a covered Employee, and who loses coverage under the Plan because of the Qualifying Event.

b. Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage.

c. If the Qualifying Event is a bankruptcy proceeding under Title 11 of the U.S. Code with respect to an Employer, a covered Retiree (who retired from employment with that Employer) and any individual who is covered under the Plan as the Spouse, surviving Spouse or Dependent Child of such a retired Employee may also be Qualified Beneficiaries. Those individuals are Qualified Beneficiaries only if (1) for the Employee, the Employee retired on or before the date of substantial elimination of coverage, and (2) for any other individuals, they were covered under the Plan on the day before the bankruptcy proceeding commenced.

Each Qualified Beneficiary (including a Dependent Child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) is offered the opportunity to make an independent election to receive COBRA continuation coverage.

4. What is a Qualifying Event?

A Qualifying Event is any of the following, if an Employee, a Spouse or a Dependent Child would lose coverage (i.e., would cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage.

For a covered Employee, the following may be a Qualifying Event:

a. The termination (other than because of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

For a covered Spouse, in addition to a., the following may be Qualifying Events:

b. The death of a covered Employee

c. The divorce or legal separation of a covered Employee from the Employee's Spouse.

d. A covered Employee's entitlement to Medicare.

For a covered Dependent Child, in addition to events a. through d. above, the following may be a Qualifying Event:

e. A Dependent Child's ceasing to satisfy the Plan's requirements for coverage as a Dependent child (e.g., attainment of the maximum age for dependency under the Plan).

Finally, for a covered Retiree (or a Spouse, surviving Spouse or Dependent Child who has coverage as the Spouse, surviving Spouse or Dependent Child of a Retiree), the following may also be a Qualifying Event:

f. A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Retiree retired at any time.

The taking of leave under the Family and Medical Leave Act ("FMLA") does not constitute a Qualifying Event. A Qualifying Event occurs, however, if a covered Employee does not return to employment at the end of the FMLA leave. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from that date. Note that the covered Employee and covered Family members will be entitled to COBRA continuation coverage even if they failed to pay the Employee portion of premiums for coverage under the Plan during the FMLA leave.

5. What Is The Election Period And How Long Must It Last

An election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. Availability of COBRA continuation coverage is conditioned upon the timely election of such coverage. The election period begins on the date of the Qualifying Event and ends 60 days after the later of:

a. The date Qualified Beneficiary would lose coverage on account of the Qualifying Event; or

b. The date notice is provided to the Qualified Beneficiary of the Qualified Beneficiary's right to elect COBRA continuation coverage.

6. Is A Covered Employee Or Qualified Beneficiary Responsible For Informing The Plan Administrator Of The Occurrence Of A Qualifying Event

Yes, in some cases. Each covered Employee or Qualified Beneficiary is responsible for notifying the Plan Administrator of the occurrence of a Qualifying Event that is:

a. A Dependent Child's ceasing to be a Dependent Child under the Plan;

b. The divorce or legal separation of the covered Employee.

A Qualified Beneficiary (or the covered Employee or Spouse) must notify the Plan Administrator within 60 days after the later of the date one of these Qualifying Events occurs. Failure to do so will result in a loss of the right to continue coverage in connection with that Qualifying Event.

This notice must be provided, along with any required documentation, to:

Plan Administrator
COBRA Qualifying Event
Board of Trustees of the Sheet Metal
Workers Local Union 268
2701 North 89th Street
Caseyville, Illinois 62232
618-397-1443

The notice must be provided, in writing, in a letter addressed to the Plan Administrator. The notice must include:

a. The covered Employee's name, address, phone number and health plan ID number;

b. The name, address, phone number and health plan ID number for any Dependent Child or Spouse whose eligibility is affected by the qualifying event;

c. A description of the Qualifying Event (or a notice of a disability determination or termination of disability status, as described below) and the date on which it occurred;

d. The following statement: "By signing this letter, I certify that the Qualifying Event described in this letter occurred on the date described in this letter." If the notice concerns a disability determination or a

change in disability status, as described below, this statement is not required; and

e. The signature of the person sending the letter.

The Qualified Beneficiary (or the covered Employee or Spouse) must also provide, along with the letter, documentation of the event that occurred, such as a photocopy of a divorce order or legal separation order showing the date of the divorce or the date the legal separation began. If a Qualified Beneficiary or anyone else has a question about what type of documentation is required, the individual should contact the Plan Administrator.

In addition to accepting a letter with the information described above, the Plan Administrator, in its discretion may develop and make available a form, which may then be completed to provide the required notice. If such a form is available, a covered Employee or a covered Spouse or Dependent Child may obtain a copy by requesting it from the Plan Administrator at the address provided in this notice.

The Plan is not required to offer the Qualified Beneficiary an opportunity to elect COBRA continuation coverage if the notice is not provided to the Plan Administrator within 60 days after the later of:

a. The date of the Qualifying Event, or

b. The date the Qualified Beneficiary would lose coverage on account of the Qualifying Event.

7. Is A Waiver Before The End Of The Election Period Effective To End A Qualified Beneficiary's Election Rights

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator.

8. When May A Qualified Beneficiary's COBRA Continuation Coverage Be Terminated

COBRA continuation coverage ends on the earliest of the following dates:

a. The last day of the applicable maximum coverage period.

b. The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

c. The date upon which the Employer ceases to provide any group health plan (including successor plans) to any Employee.

d. The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other group health plan that does not include an exclusion or limitation with respect to any pre-existing condition that would affect the Qualified Beneficiary.

e. The date, after the date of the election, that the Qualified Beneficiary is first entitled to Medicare. This date does not apply for anyone who became a Qualified Beneficiary because of a bankruptcy proceeding.

f. For a Qualified Beneficiary who is entitled to a disability extension, the later of:

(1) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the first month that is later than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(2) The last day of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA Plan Participants (for example, for fraud).

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

9. What Are The Maximum Coverage Periods For COBRA Continuation Coverage

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

a. If the Qualifying Event is a termination of employment or reduction of hours of employment, except as provided in paragraphs b. and c. below,

the maximum coverage period ends 18 months after the Qualifying Event.

b. If the Qualifying Event is a termination of employment or reduction of hours of employment and the Qualified Beneficiary is entitled to a disability extension, the maximum coverage period ends 29 months after the Qualifying Event if there is a disability extension (unless the disability ends before the end of that 29-month period).

c. If a covered Employee becomes entitled to Medicare before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

   (1) 36 months after the date the covered Employee becomes entitled to Medicare; or

   (2) 18 months (or up to 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

d. For a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is a covered Retiree (or a surviving Spouse who was participating in the Plan as a surviving Spouse on the day before the bankruptcy Qualifying Event) ends on the date of the covered Retiree's (or surviving Spouse's) death. The maximum coverage period for a Qualified Beneficiary who is the Spouse or Dependent Child of the covered Retiree ends 36 months after the death of the covered Retiree.

e. For a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

f. For any Qualifying Event other than those described above, the maximum coverage period ends 36 months after the Qualifying Event.

10. Under What Circumstances Can The Maximum Coverage Period Be Expanded

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second

Qualifying Event that gives rise to a 36-month maximum coverage period, the maximum coverage period may be expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying events. In no circumstances can the COBRA maximum coverage period be expanded to last longer than 36 months after the date of the first Qualifying Event.

However, no event is a second Qualifying Event unless that event would have been an initial Qualifying Event if it had occurred for a covered Employee. For example, a covered Employee's entitlement to Medicare cannot be a second Qualifying Event for a Spouse or a Dependent Child unless a covered Employee's entitlement to Medicare would have been an initial Qualifying Event (i.e., unless an Employee's entitlement to Medicare would have resulted in a loss of coverage for the Spouse or Dependent Child).

A Qualified Beneficiary (or a covered Employee or Spouse) must notify the Plan Administrator of a second Qualifying Event within 60 days after the later of the date of the Qualifying Event or the date the Qualified Beneficiary would lose coverage because of the Qualifying Event. To submit this notice, the Qualified Beneficiary must follow the procedures described above in subsection 5.

11. How Does A Qualified Beneficiary Become Entitled To A Disability Extension

A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary (or a covered Employee or Spouse) must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. To submit this notice, the Qualified Beneficiary must follow the procedures described above in subsection 6.

If a Qualified Beneficiary becomes entitled to a disability extension and then there is a final determination by the Social Security Administration, under Title II or XVI of the Social Security Act, that the Qualified Beneficiary is no longer disabled, the Qualified Beneficiary (or the covered Employee or someone else) must notify the Plan Administrator of that determination

within 30 days after the date of the final determination. The notice should take the form of a letter as described above in subsection 6.

12. Can A Plan Require Payment for COBRA Continuation Coverage

Yes. For any period of COBRA continuation coverage, the Plan will require the payment of an amount equal to 102% of the actual cost of coverage, except the Plan will require the payment of an amount equal to 150% of the actual cost of coverage for any period of COBRA continuation coverage covering a disabled Qualified Beneficiary that would not be required to be made available in the absence of a disability extension.

13. Must The Plan Allow Payment For COBRA Continuation Coverage To Be Made In Monthly Installments

Yes.

14. What Is Timely Payment For Payment For COBRA Continuation Coverage

For regular monthly payments, Timely Payment means a payment made by the first day of the month in question (the "due date") or within a 30-day grace period beginning on that due date.

Notwithstanding the above paragraph, the Plan will not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is sent to the Plan.

15. Special Rules for Medicare-Eligible Individuals

In general, if an individual does not enroll in Medicare Part A or B when first eligible because the individual is still employed, the individual will subsequently have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after the individual's employment ends; or
- The month after the individual's group health plan coverage based on current employment ends.

If an individual does not enroll in Medicare and elects COBRA continuation coverage instead, the individual may have to pay a Part B late enrollment penalty and may have a gap in coverage if the individual decides to elect Part B later. If an individual elects COBRA continuation coverage and later enrolls in Medicare Part A or B before the COBRA continuation coverage ends, the

Plan will terminate continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if the individual enrolls in the other part of Medicare after the date of the election of COBRA coverage.

If an individual is enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if the individual is not enrolled in Medicare.

For more information visit:

https://www.medicare.gov/medicare-and-you and

https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

16. Special Additional Continuation Coverage Election Period for "TAA-Eligible Individuals"

In addition to the other COBRA rules described in the Plan, there are some special rules that apply if an individual is classified as a "TAA-eligible individual" by the U.S. Department of Labor. (This applies only if the individual qualifies for assistance under the Trade Adjustment Assistance Reform Act of 2002, because the individual became unemployed as a result of increased imports or the shifting of production to the other countries.)

If an individual who is classified by the Department of Labor as a TAA-eligible individual does not elect continuation coverage when the individual first loses coverage, the individual may qualify for an election period that begins on the first day of the month in which the individual becomes a TAA-eligible individual and lasts up to 60 days. However, in no event does this election period last later than 6 months after the date of the individual's TAA-related loss of coverage. If a TAA eligible individual elects continuation coverage during this special election period, continuation coverage would begin at the beginning of that election period, but, for purposes of determining the maximum required COBRA coverage period, the coverage period will be measured from the date of the original Qualifying Event, i.e., the TAA-related loss of coverage.

The Trade Adjustment Assistance Act also provides for a tax credit that may apply to some expenses for continuation coverage. An affected individual should consult with a financial advisor if the individual has questions about

the tax credit. More information about the TAA is available at www.doleta.gov/tradeact.

SECTION H. MEDICAL MANAGEMENT PROGRAM

Medical Management Program Phone Number

Meritain Medical Management: 800-242-1199

1. Medical Management

Medical Management is a program designed to help ensure that all Covered Persons receive necessary and appropriate healthcare while avoiding unnecessary expenses. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other healthcare provider.

2. Precertification

Before a Covered Person is admitted to a medical facility or receives items or services from the list below, the Medical Management Program Administrator will, based on clinical information from the provider or facility, certify the care according to the Medical Management Program Administrator's policies, procedures and guidelines. Once an inpatient setting has been pre-certified, working directly with the Covered Person's Physician, the Medical Management Program Administrator will identify and approve the most appropriate and cost-effective setting for the treatment as it progresses. The Medical Management Program Administrator will also assist and coordinate the initial implementation of any services needed post hospitalization (called discharge planning) with the attending Physician and the facility. This could include registering the Covered Person for specialized programs or case management when appropriate.

The Covered Person's provider may pre-certify treatment; however, the Covered Person should verify prior to incurring covered charges that the provider has obtained precertification. If treatment is not pre-certified within the time periods described below a retrospective review may be performed. A retrospective review (as directed by the Plan) will determine if the services were Medically Necessary and would have been approved had the required phone call been made, provided the covered charges meet all other Plan provisions and requirements. However, any charges not deemed Medically Necessary will be denied.

3. Case Management

Depending on the level of care needed, the case manager will coordinate and implement the case management program by providing guidance and information on available resources and suggesting the most appropriate

treatment plan. All parties involved (e.g., the Plan, attending Physician, and patient) must all agree to the alternate individually tailored treatment plan. Each treatment plan is specific to that patient and should not be seen as appropriate or recommended for any other patient, even with the same diagnosis. Case management is a voluntary service. There are no reductions of benefits or penalties if a Covered Person chooses not to participate.

4. Important Timeframes to Know

The Covered Person, their Physician, the Facility or someone acting on the Covered Person's behalf, should call the Medical Management Program Administrator (at the number listed above and on the Covered Person's Identification Card) within the following time frames for a:

Non-emergency admission	48 hours before the scheduled admission
Non-emergency services	48 hours before you are scheduled to receive the services
Emergency admission	Within 48 hours or if later, the next business day after you are admitted

If the attending Physician feels that it is Medically Necessary for a patient to receive services for a greater length of time than initially pre-certified, the attending Physician or the medical facility should request the additional service or days as soon as reasonably possible, but no later than the final authorized day.

5. List of Items and/or Services that require Precertification

The below items and/or services, if covered charges under the Plan, should be pre-certified before any medical services are provided. To determine whether a benefit is covered or excluded, please review the Covered Medical Expenses and/or Exclusions and Limitations sections of this Plan.

All Inpatient Admissions:

- Acute
- Long-Term Acute Care
- Rehabilitation Facility
- Mental Disorder I Substance Use Disorder
- Residential Treatment Facility
- Transplant
- Skilled Nursing Facility

Diagnostic Services (Outpatient and Physician):

- CT for non-orthopedic
- MRI for non-orthopedic
- PET
- Capsule endoscopy
- Genetic testing, including BRCA
- Sleep study

Surgery (including in a Physician's office):

- Breast and bone marrow biopsy
- Biopsies (excluding skin)
- Vascular Access Devices for the infusion of chemotherapy (including, but not limited to, PICC and Central Lines)
- Thyroidectomy, partial or complete
- Open prostatectomy
- Creation and revision of Arteriovenous Fistula (AV Fistula) or Vessel to Vessel Cannula for dialysis
- Oophorectomy, unilateral and bilateral
- Back Surgeries and hardware related to Surgery
- Osteochondral Allograft, knee
- Hysterectomy (including prophylactic)
- Autologous chondrocyte implantation, Carticel
- Transplant (excluding cornea)
- Balloon sinuplasty
- Sleep apnea related Surgeries, limited to:
    - Radiofrequency ablation (Coblation, Somnoplasty)
    - Uvulopalatopharyngoplasty (UPPP), including laser-assisted procedures

Continuing Care Services (Outpatient and Physician):

- Chemotherapy (including oral)
- Radiation therapy
- Oncology and transplant related injections, infusions and treatments (e.g., CAR-T, endocrine and immunotherapy), excluding supportive drugs (e.g., antiemetic and antihistamine)
- Dialysis
- Hyperbaric oxygen
- Home healthcare
- Durable Medical Equipment, limited to electric/motorized scooters or wheelchairs and pneumatic compression devices

Monthly High-Cost Drugs that are $2,000 or more and are:

- Injectables
- Infusion therapies

6. Important Notes

- Precertification is recommended if a procedure could be considered Experimental and/or Investigational or potentially Cosmetic in nature (such as, but not limited to: abdominoplasty, cervicoplasty, liposuction/lipectomy, mammoplasty (augmentation and reduction – includes removal of implant), Morbid Obesity procedures, septoplasty, etc.)
- Precertification is NOT REQUIRED for a maternity delivery admission, unless the stay extends past 48 hours for vaginal delivery or 96 hours for a cesarean section. A Hospital stay begin at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth. If a newborn remains hospitalized beyond the time frames specified, the confinement should be pre-certified with the Medical Management Program Administrator.
- High-Cost Drugs are drugs that are covered under the medical benefits section of the Plan. This requirement does not apply to drugs covered under the Prescription Drug Program.

7. Precertification Does Not Guarantee Payment

Precertification of the above benefits ensures the service being rendered is Medically Necessary and appropriate. All benefits/payments are subject to the patient's eligibility for benefits under the Plan. For benefit payment, services rendered must be considered a covered charge and are subject to all other provisions of the Plan.

8. To File a Complaint or Request an Appeal to a Non-Certification

If it is determined that the item and/or services are not Medically Necessary, the notification to the Covered Person will explain why. Verbal appeal requests and information regarding the appeal process should be directed to the Medical Management Program Administrator as identified above.

9. High-Cost Drug Management

The primary objective of the High-Cost Drug Management program is to provide assistance when a Covered Person has been prescribed a high-cost drug that exceeds $2,000 per month and is covered under the medical benefits section of the Plan.

The High-Cost Drug Management program helps coordinate the most effective way to reduce expenses associated with the high-cost drug. Specially trained case managers will make recommendations based on the terms of the Plan to ensure the medication is being obtained through the most cost-effective method.

If the Covered Person is not currently utilizing the most cost-effective method, the case manager will make a recommendation to how to obtain the medication from the most cost-efficient Participating Provider. The program includes one-on-one coaching based on Plan provisions, support and education to improve adherence and avoid complications.

This is a voluntary service. There are no reductions of benefits or penalties if the Covered Person and family choose not to participate or comply with recommendations or suggestions provided by case managers.

SECTION I. MEDICAL BENEFITS

The following is a description of the medical benefits provided under the Plan. The Plan provides benefits only with respect to covered services and supplies which are Medically Necessary in the specific treatment of a covered Illness or Injury, unless specifically mentioned otherwise in Covered Medical Expenses.

1. Benefit Payment

Each calendar year, except as otherwise provided in the Plan, benefits will be paid for covered charges of a Covered Person that are in excess of the deductible and any copayments, up to the Usual and Customary Charge amount, if applicable. Payment will be made at the percentages shown as the reimbursement percentage in the Schedule of Benefits.

2. Covered Medical Expenses

Covered charges are the Usual and Customary Charges where applicable, incurred for the following services and supplies:

A charge is considered incurred on the date that the service or supply is performed or furnished.

If you are being treated at a Network facility, services and supplies rendered in connection with your treatment by Non-Network providers will be covered at the Network cost-share to the extent required by the No Surprises Act, without regard to the Non-Network cost-share listed in the Schedule of Medical Benefits.

a. Hospital Care

Covered medical services and covered supplies furnished by a Hospital or Ambulatory Surgical Center. Covered Hospital charges will be payable as shown in the Schedule of Medical Benefits. This benefit includes Hospital expenses for covered dental services if the attending Physician certifies that care in a Hospital is Medically Necessary to safeguard the health of the patient.

Room and board, including non-routine nursing care, not to exceed the cost of a semiprivate room or other accommodations if the attending Physician certifies Medical Necessity. If a private room is the only accommodation available, the Plan will cover an amount equal to the prevailing semiprivate room rate in that facility.

Charges for an Intensive Care Unit (ICU) and Coronary Care Unit (CCU) stay are payable as described in the Schedule of Medical Benefits and based on the Hospital's ICU or CCU charge.

b. Pregnancy Care

The care and treatment of a Pregnancy is covered the same as any other Illness. This benefit includes services and supplies furnished by a Birthing Center, as shown in the Schedule of Medical Benefits. One ultrasound and sonogram is allowed during a normal Pregnancy.

The Plan generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not, under federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

A shorter stay at a Medical Care Facility is permissible, and the Plan will allow two post-discharge visits, at least one of which will be provided at home, if the attending Physician consents to the shorter stay after consultation with the mother and provided notification is given to Medical Management.

c. Skilled Nursing Facility, Extended Care Facility and Rehabilitation Facility Admissions

The room and board, nursing care, medical services and supplies furnished by a Skilled Nursing Facility, extended care facility or rehabilitation facility will be payable when approved by Medical Management, as outlined in the Schedule of Medical Benefits. This benefit does not include treatment related to or for a Mental Disorder or Substance Use Disorder diagnosis. In order to be eligible, the following must occur:

(1) The Covered Person is confined as a bed patient in the facility within seven days of a Hospital confinement;

(2) The attending Physician certifies that confinement is needed for further care of the condition that caused the Hospital confinement; and

(3) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility, extended care facility or rehabilitation facility.

Covered charges for a Covered Person's care in these facilities are limited to the facility's semiprivate room rate.

Benefits are limited as outlined in the Schedule of Benefits.

d. Physician Care

Inpatient, outpatient, office or home professional services of a Physician for surgical or medical services to treat an Illness or Injury are covered as outlined in the Schedule of Medical Benefits. Inpatient care also includes the following:

(1) Treatment of Attention Deficit Disorder (ADD) and/or Attention Deficit Hyperactivity Disorder (ADHD) when treated by a Physician with an approved treatment plan.

(2) Second surgical opinion (and/or second medical opinion) and necessary third surgical or medical opinions.

(3) Sex counseling or treatment for or related to sexual dysfunction or inadequacies caused by an organic disease or accidental injury only with an approved treatment plan, for Covered Persons age 18 and over.

(4) Multiple surgical procedures, subject to the following provisions:

(a) Two or more surgical procedures performed during the same session through the same incision, natural body orifice or operative field. The amount eligible for consideration is the Usual and Customary Charge for the largest amount billed for one procedure plus 50% of the sum of Usual and Customary Chargers for all other procedures performed; or

(b) Two or more surgical procedures performed during the same session through different incisions, natural body orifices or operative fields. The amount eligible for consideration is the Usual and Customary Charge for the largest amount billed for one procedure, plus 50% of the sum of Usual and Customary Charges billed for all other procedures performed.

(5) Assistant Surgeon, if required.

e. Private Duty Nursing Care

Private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N). Covered charges for this service will be included to the following extent:

(1) Inpatient Nursing Care. Charges are covered only when care is Medically Necessary and not Custodial Care in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit. Inpatient Private Duty Nursing must be supported by a certification from the attending Physician.

(2) Outpatient Nursing Care. Charges are covered only when care is Medically Necessary and not Custodial Care in nature. Charges covered for nursing Outpatient Care billed by a Home Health Care Agency are shown below, under Home Health Care Services and Supplies. Private duty nursing Outpatient Care not billed by a Home Health Care Agency must be supported by a certification and a treatment plan from the attending Physician.

f. Home Health Care Services and Supplies

Charges for Home Health Care Services and Supplies are covered only for care and treatment of an Illness or Injury when Hospital or Skilled Nursing Facility confinement would otherwise be required. The care must start within seven days following the end of a Hospital stay as a bed patient. The diagnosis, care and treatment must be supported by a certification and a treatment plan from the attending Physician, and must be recertified every 60 days.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care maximum as outlined in the Schedule of Medical Benefits.

Benefits are limited as outlined in the Schedule of Medical Benefits.

g. Hospice Care Services and Supplies

Covered charges for Hospice Care Services and Supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the Covered Person is not expected to live more than six months, and has placed the Covered Person under a Hospice Care Plan and only as outlined in the Schedule of Medical Benefits. A Hospice Care Plan primarily provides palliative, supportive and other related care.

Covered bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's covered Spouse and/or covered Dependent Children. Bereavement services must be furnished within six months after the patient's death.

Benefits are limited as outlined in the Schedule of Medical Benefits.

h. Medical Management

Care or treatment recommended and approved by Medical Management.

i. Other Medical Services and Supplies

Services and supplies not otherwise included in the items listed above are covered as follows:

(1) Allergy Services includes allergy testing, preparation of serum and allergy injections, as outlined in the Schedule of Medical Benefits.

(2) Ambulance transportation provided by a professional ambulance service for local land or air transportation for an Emergency Medical Condition. A charge for this service will be considered a covered charge only if the service is to the nearest Hospital or emergency care facility where Medically Necessary treatment can be provided. Benefits are also provided for transportation from one Medical Care Facility to another, when Medically Necessary.

(3) Amniocentesis. One regular amniocentesis per pregnancy for the following reasons: mother's blood type is negative; in late pregnancy to determine maturity of lungs of fetus if baby is post mature; to determine if needs of fetus are being adequately met in utero; or if cesarean section is Medically Necessary.

(4) Anesthetic services when performed by a licensed anesthesiologist or certified registered nurse anesthetist in connection with a covered surgical procedure.

(5) Blood and blood derivatives that are not donated or replaced. Administration of these services is also considered an eligible expense, including handling charges for storing a Covered Person's own blood prior to surgery.

(6) Breast reduction surgery that is Medically Necessary.

(7) **Cardiac rehabilitation** as deemed Medically Necessary, provided services are rendered on an outpatient basis under the supervision of a Physician and in a Medical Care Facility as defined by the Plan.

(8) **Chemotherapy and radiation treatment** with radioactive substances. The materials and services of technicians are included.

(9) **Contact lenses and eyeglasses** are covered when needed to replace the human lens lost due to cataract surgery and other intraocular surgeries. Benefits for contact lenses or eyeglasses are limited to the initial prescription only.

(10) **Dental services.** Charges for dental services rendered by a Physician, Dentist or oral surgeon for treatment within 24 months of an Injury to the jaw or natural teeth, including the initial replacement of these teeth and any necessary dental x-rays, provided such Injury is the result of an accident. Hospital charges are also covered if the Plan Participant is a bed patient.

In addition, charges for the removal of fully (but not partially) impacted wisdom teeth are covered, including anesthesia.

(11) **Durable Medical Equipment**, including oxygen and oxygen equipment, if deemed Medically Necessary. A statement is required from the prescribing Physician describing how long the equipment is expected to be Medically Necessary. This statement will determine whether the equipment will be rented or purchased. Benefits are limited to the fair market value of the equipment at the time of purchase. If the equipment is purchased, benefits include expenses related to necessary repairs and maintenance. Initial replacement equipment will be covered if the replacement equipment is required due to a change in the Covered Person's physical condition or purchase of new equipment will be less expensive than repair of existing equipment.

(12) **Foot treatment** if deemed Medically Necessary for conditions, including removal of nail foots, surgical procedures or treatment of a metabolic or peripheral vascular disease. Routine foot care such as non-surgical treatment of weak, strained, flat, unstable or unbalanced feet; metatarsalgia or bunions; corns; callouses; and toenails is excluded.

(13) Diagnostic **laboratory studies** that are Medically Necessary.

(14) Covered charges for care, supplies and treatment of a **Mental Disorder or Substance Use Disorder**, including partial hospitalization and intensive outpatient treatment. The Plan also covers medically necessary Applied Behavioral Analysis Therapy when ordered by a Physician and subject to the limitations outlined in the Schedule of Medical Benefits.

(15) Medically Necessary surgical treatment of **Morbid Obesity.**

(16) **Occupational therapy** by a qualified Physician or a licensed occupational therapist. Therapy must be ordered by a Physician to restore body function lost due to an Injury, Illness or surgery. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy. Benefits are limited as outlined in the Schedule of Medical Benefits.

(17) **Organ or tissue transplant** expenses. Only the following procedures are eligible provided the procedure is not considered Experimental or Investigational:

(a) Cornea transplant;

(b) Artery or vein replacements;

(c) Kidney transplants;

(d) Joint replacements;

(e) Heart valve replacements;

(f) Implantable prosthetic lenses in connection with cataracts;

(g) Prosthetic bypass or replacement vessels;

(h) Bone marrow transplants;

(i) Heart transplants;

(j) Heart and lung transplants; and

(k) Liver transplants.

Benefits are payable for services provided by Participating Providers only, unless Non-Participating Providers are specifically approved by Medical Management. No other replacement of tissue or organs is covered by the Plan.

There is no coverage under the Plan for charges incurred in obtaining donor organs or tissues. This includes charges for:

(l) Evaluating the organ or tissue;

(m) Removing the organ or tissue from the donor; and

(n) Transportation of the organ or tissue from within the United States of America and Canada to the place where the transplant is to take place.

(18) Orthotics that are the original fitting, adjustment and placement of appliances such as braces, casts, splints, crutches, cervical collars, head halters or other appliances to aid in their function when impaired, other than foot orthotics.

(19) Physical therapy provided by a qualified Physician or a licensed physical therapist. Therapy must be in accord with a Physician's exact orders as to the type, frequency and duration of therapy and for conditions which are subject to significant improvement through short-term therapy. Eligible expenses do not include maintenance therapy. Benefits are limited as outlined in the Schedule of Medical Benefits.

(20) Pre-admission and pre-surgical testing within seven days of a scheduled inpatient Hospital admission, as outlined in the Schedule of Medical Benefits.

(21) The initial purchase and fitting of fitted **prosthetic devices**, artificial limbs and artificial eyes, which replace body parts. Replacement of such devices is not covered.

(22) Pulmonary rehabilitation following surgery and upon written prescription by the primary Physician.

(23) Reconstructive Surgery. Correction of abnormal congenital conditions, birth abnormalities resulting in the malformation or absence of a body part or conditions caused by an accidental Injury or covered Illness. Reconstructive surgery benefits for abnormal congenital conditions or birth abnormalities is limited to a covered Dependent Child whose abnormal congenital condition or birth abnormality manifests itself within five years of the Dependent Child's birth and impairs a body function.

Reconstructive Mammoplasties will also be considered covered charges. Mammoplasty benefits include reimbursement for:

(a) Reconstruction of the breast on which a mastectomy has been performed;

(b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(c) Coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas;

in a manner determined in consultation with the attending Physician and the patient.

No more than two breast prostheses and/or post-mastectomy bras will be covered within a 12-month period unless approved by the Plan Administrator or a designated agent of the Plan Administrator.

(24) Preventive or Routine Care. Covered charges under Medical Benefits are payable for Routine Care as outlined in the Schedule of Medical Benefits. Routine colonoscopies are covered in accordance with the U.S. Preventive Services Task Force recommendations with a rating of A or B.

For the duration of the Public Health Emergency related to COVID-19, the Plan will cover COVID preventive services that receive at least one of the following recommendations:

- A United States Preventive Services Task Force (USPSTF) recommendation with an A or B rating.
- An immunization recommendation from the Advisory Committee on Immunization Practices to the Centers for Disease Control (CDC).

(25) Sexual dysfunction. Care and treatment of sexual dysfunction, including penile implants.

(26) Sleep disorder treatment that is for the diagnosed conditions of sleep apnea, nocturnal seizures and narcolepsy, including biofeedback, as shown in the Schedule of Medical Benefits. Treatment must be pre-certified with Medical Management.

(27) Speech therapy provided by a qualified Physician or a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (a) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a Covered Person; (b) an Injury; or (c) an Illness.

The therapy cannot be for or in connection with treatment of remedial reading, special education, self-care/self-help training, or

supplies used in connection with such treatment. There must be continuing measurable progress demonstrated at regular intervals.

(28) Spinal Manipulation/Chiropractic Care services by a licensed M.D., D.O. or a D.C. Benefits are limited as outlined in the Schedule of Medical Benefits.

(29) Sterilization procedures other than the reversal of surgical sterilization.

(30) Supplies such as surgical dressings, jobst stockings, braces, crutches, casts, splints, trusses and ostomy supplies.

(31) Temporomandibular Joint (TMJ) dysfunction. Benefits are limited as outlined on the Schedule of Medical Benefits.

(32) Well newborn nursery/Physician care charges.

(a) **Routine nursery care.** Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room and board charges, circumcision and other normal routine care.

This coverage is only provided if the newborn is properly enrolled.

The benefit is limited to charges for nursery care for the newborn covered Dependent Child while Hospital-confined as a result of the Dependent Child's birth.

(b) **Physician care.** Benefits are limited to charges incurred by a newborn covered Dependent Child while the newborn Dependent Child is Hospital-confined as a result of the Dependent Child's birth, including circumcision.

(33) Diagnostic **X-rays**, including ultrasounds only if the attending Physician certifies that the procedure is Medically Necessary.

SECTION J. EXCLUSIONS AND LIMITATIONS

THIS IS NOT MEANT TO BE ALL INCLUSIVE. THE EXCLUSIONS AND LIMITATIONS STATED DO NOT NECESSARILY INCLUDE ALL CHARGES WHICH ARE EXCLUDED OR LIMITED. ONLY THOSE CHARGES LISTED AS COVERED CAN BE ASSUMED PAYABLE.

Note: All exclusions related to Prescription Drugs Benefits are shown in the Prescription Drug Program section.

No benefits will be payable under this Plan for charges incurred for:

1. **Abortion.** Services, supplies, care or treatment in connection with an elective abortion. This exclusion does not apply to terminated pregnancies, including those for covered Dependent daughters, when the life of the mother is endangered by the continued Pregnancy, in the case of fetal abnormality, or when the Pregnancy is the result of documented rape or incest. If complications arise after the performance of any abortion, any expenses incurred to treat those complications will be eligible, whether the abortion was eligible or not.
2. **Acupuncture.**
3. **Administrative costs.** Administrative costs of completing claim forms, itemized bills, medical reports or for providing records, mailing and/or shipping expenses, expenses for broken appointments or expenses for telephone calls.
4. **Adoption expenses.**
5. **Complications of non-covered surgery or treatment.** Care, services or treatment required as a result of complications from any non-covered surgery or treatment unless otherwise noted.
6. **Contraceptives,** including oral contraceptives, injectable contraceptives, contraceptive implants and devices, including the administration of the contraceptive.
7. **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance, Custodial Care or care in a sanitarium.
8. **Dental care** except as specified in the Schedule of Medical Benefits or the Medical Benefits section above.
9. **Educational or vocational testing.** Services for educational or vocational testing or training except as specified in the "Schedule of Medical Benefits" section or the "Medical Benefits" section above.

10. **Environment change.** Inpatient hospital care for environmental change or care in institutions providing education in special environments.

11. **Excess charges.** Expenses in excess of the Usual and Customary Charge.

12. **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation and occupational or physical therapy covered by the Plan.

13. **Experimental or Investigational.** Expenses for treatment, procedures, devices, drugs or medicines which are determined to be Experimental or Investigational.

14. **Extreme Sports.** Expenses for injuries sustained during participation in any sport or athletic activity undertaken for thrill seeking or which exposes the individual to abnormal or extreme risk of injury, as determined by the Trustees. Examples of extreme sports/activities include, but are not limited to:

    - MMA Fighting/Training
    - Motocross Racing
    - Motor Vehicle Competition including racing and training
    - Solo skydiving/hang-gliding
    - Rodeo, show jumping or horse racing
    - Scuba Diving as a professional or without an underwater diving certificate
    - A sporting activity for pay
    - Rock/Mountain Climbing
    - Roller Derby
    - Parkour
    - Zorbing
    - Powerblocking
    - Adventure racing
    - Alpinism/mountaineering
    - BASE jumping
    - BMX racing

- Acrobatics or stunt flying
- Powerboat racing

15. **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

16. **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

17. **Foot orthotics.** Foot orthotics including all equipment, devices, shoe inserts, arch supports, lifts and corrective shoes.

18. **Gene Therapy.** Services, supplies, care, drugs or treatment-related to gene therapy.

19. **Genetic Testing** including diagnostic testing of genetic information and counseling.

20. **Government coverage.** Expenses for services furnished by or for the United States government or any other government, unless payment is legally required.

21. **Group counseling.**

22. **Growth hormone therapy.**

23. **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

24. **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting unless loss of hearing is due to a covered Injury or Illness.

25. **Hospital admissions on Friday/Saturday/Sunday other than admissions related to an Emergency Medical Condition.** Care, treatment and services billed by a Hospital for admissions on a Friday, Saturday or Sunday which are not related to an Emergency Medical Condition. This does not apply if surgery is performed within 24 hours of admission.

26. **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and who is paid by the Hospital or facility for the service.

27. **Illegal act.** Expenses for injuries incurred during the commission or attempted commission of any criminal act, as defined by applicable federal or state law, involving, but not limited to, one or more of the following:

    a. The use of alcohol or illegal drugs, excluding minor traffic violations; or

    b. Violence or the threat of violence to another person; or

    c. The Covered Person's use of a firearm, explosive or other weapon likely to cause physical harm or death.

    This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

28. **Infertility.** Care, supplies, services and treatment for infertility, artificial insemination or in vitro fertilization.

    Impregnation procedures, including, but not limited to, artificial insemination, in-vitro fertilization, embryo and fetal implantation and G.I.F.T. (gamete intrafallopian transfer), are also excluded.

29. **Marital counseling.**

30. **Not Medically Necessary.** Expenses for goods or services that are not Medically Necessary or are primarily Cosmetic in nature.

31. **Morbid Obesity.** Non-surgical treatment of Morbid Obesity and expenses for surgical treatment of Morbid Obesity if not Medically Necessary.

32. **No charge.** Care, treatment and services for which there would not have been a charge if no coverage had been in force.

33. **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay or in excess of the benefit payable under the Plan.

34. **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; and care, treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the injury or illness.

35. **Not specified as covered.** Non-traditional services, treatments and supplies which are not specified as covered under the Plan, including but not limited to holistic, massage therapy, rolfing, hypnosis, homeopathic, continuous epidural anesthesia, biofeedback (except as specified) and naturopathic services.

36. **Nuclear accidents.** Services related to any actual or alleged nuclear reaction, nuclear radiation, radioactive contamination or radioactive substance.

37. **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Illness. This exclusion does not apply to Medically Necessary surgical treatment of Morbid Obesity.

38. **Occupational.** Any expenses incurred as a result of accidental bodily Injury or Illness arising out of or in the course of any occupation or employment for wage or profit, or for which the Covered Person is entitled to benefits under workers' compensation or occupational disease law, whether or not a claim is made for those benefits.

39. Charges for **organ or tissue transplants** rendered by a Non-Participating Provider, unless otherwise specified.

40. **Outside the United States.** Services or supplies incurred outside the United States if the Covered Person traveled to the foreign country or locality for the sole purpose of receiving the services or supplies.

41. **Personal comfort items.** Personal comfort items or other equipment, including, but not limited to, television, telephone, guest meals, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings (except as specified), non-prescription drugs and medicines, first-aid supplies, non-hospital adjustable beds, healing pads, hot water bottles, waterbeds, hot tubs, swimming pools, or any other equipment that could be used in the absence of an Illness or Injury.

42. **Plan exclusions.** Charges excluded by the Plan as noted in this document.

43. **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

44. **Replacement prosthetics.** Replacement of prosthetic devices is not covered by the Plan.

45. **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under the Plan or after coverage ceased under the Plan.

46. **Sleep disorders.** Care, treatment, services and supplies for sleep disorders unless for the diagnosed conditions of sleep apnea, nocturnal seizures and narcolepsy.

47. **Surgical sterilization reversal.** Expenses related to reversal of surgical sterilization.

48. **Surrogate parenting.** Expenses related to surrogate parenting.

49. **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense.

50. **War, etc.** Any expenses resulting from losses which are due to riot, revolt, war or any act of war, whether declared or not.

SECTION K. PRESCRIPTION DRUG BENEFITS

1. Prescription Drug Program

This Prescription Drug Program is an independent program, separate from medical coverage. Citizens Rx participating Pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. In order to receive the full benefit of the Prescription Drug Program, a Covered Person must use participating Pharmacies and present the Covered Person's ID card. Citizens Rx is the administrator of the Prescription Drug Program.

2. Copayments

The copayment is applied to each covered Pharmacy drug or mail order drug charge and is shown in the Schedule of Prescription Drug benefits. The copayment amount is not a covered charge under the Medical Benefits and does not apply to the out-of-pocket maximum discussed in the Schedule of Benefits. With the exception of maintenance medications, retail Pharmacy prescriptions are limited to a 31-day supply. A retail or mail order prescription for a maintenance medication is limited to a 90-day supply.

3. Retail or Mail Order Maintenance Medications

Maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.) may be purchased at a retail Pharmacy or by mail order. Because of volume buying, this option offers Covered Persons significant savings on their prescriptions.

4. Direct Reimbursement

If a Prescription Drug is purchased from a non-participating Pharmacy, or a participating Pharmacy when the Covered Person's ID card is not used, the Covered Person must pay the pharmacist the full amount for the prescription. In order for reimbursement to occur, the Covered Person must complete a direct reimbursement form, obtained from the Plan Administrator, attach the receipt, and submit it to the Prescription Drug Program administrator at the following address:

Citizens Rx
1144 Lake Street
Oak Park, Illinois 60301

The Covered Person will be reimbursed the amount that would have been paid to a participating Pharmacy, less the applicable copayment.

5. Specialty Drugs

Specialty medications are used in treating serious illnesses and conditions such as cancer, hemophilia, hepatitis C, multiple sclerosis, and rheumatoid arthritis. Specialty drugs will be filled through Citizens Rx's specialty pharmacy.

For specialty drugs, the Plan will pay the first 50% of the cost of the specialty medication obtained through Citizens Rx's specialty pharmacy. Citizens Rx will then assist the individual in applying for any available copay assistance and coupons from pharmaceutical manufacturers and for payment from other plans covering the individual.

If payment from other sources is received, the Plan will pay the remaining cost of the medication after the third party payments are applied with no amount due from the individual.

If there is no payment available from other sources, the individual will only be responsible for the brand copay amount as shown in the prescription drug schedule of benefits.

Coupons, copay assistance and other forms of financial assistance and any amounts not paid out of the Participant or Dependent's "pocket" are not counted towards the out-of-pocket maximum.

6. Covered Prescription Drugs

The Plan covers Prescription Drugs except as specified in the "Expenses Not Covered" section below. In addition, the following drugs are also covered:

a. Insulin, glucose monitors, insulin syringes and other diabetic supplies when prescribed by a Physician.

b. Smoking deterrents.

7. Expenses Not Covered

The Prescription Drug Program does not cover a charge for any of the following:

a. **Administration.** Any charge for the administration of a covered Prescription Drug.

b. **Appetite suppressants.**

e. **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments or any similar device.

f. **Dietary supplements.**

g. **Drugs used for Cosmetic purposes.** Charges for drugs used for Cosmetic purposes, such as anabolic steroids or medications for hair growth or removal.

h. **Drugs with a cost of $5,000 or more,** unless Medically Necessary for the treatment of a life-threatening condition or such drug is the only line of treatment for the applicable condition. The term "life-threatening condition" means any disease or condition from which death is likely unless the disease or condition is treated.

i. **Experimental or Investigational.** Experimental or Investigational drugs and medicines, even though a charge is made to the Covered Person.

j. **Fertility drugs.** A charge for fertility medication.

k. **Gene Therapy.** Services, supplies, care, drugs or treatment related to gene therapy.

l. **Growth hormones.** Drugs to enhance physical growth or athletic performance or appearance.

m. **Immunization.** Immunization agents or biological sera.

n. **Injectable supplies.** A charge for hypodermic syringes or needles (other than for insulin).

o. **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while confined in a Hospital or institution. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

p. **Investigational.** A drug or medicine labeled: "Caution – limited by federal law to investigational use."

q. **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

r. **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

s. **No prescription.** Over the counter medications, with the exception of insulin, insulin syringes and insulin-related diagnostic materials.

t. **Refills.** Any refill requested more than one year after the date ordered by the Physician.

u. **Drugs for treatment of sexual dysfunction or impotency.**

v. **Vitamins.** Vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

w. **Topical Testosterone Products.** All topical testosterone products are excluded under the Plan. Coverage will only be provided for injectable testosterone.

x. **Brand Name Proton Pump Inhibitors (PPIs).** All brand name PPIs including, but not limited to, Nexium, Prilosec and Pepcid.

SECTION L. SHORT TERM DISABILITY BENEFITS

NOTE: Short Term Disability benefits are only provided for covered Employees. No Short-Term Disability benefits are provided for Retirees, Non-Bargained Employees of an Employer (other than Employees of Sheet Metal Workers Local 268 or one of the fringe benefits funds administered by Sheet Metal Workers Local 268), or Dependents.

1. What is Short Term Disability

After the Plan Administrator receives satisfactory evidence from the Employee's Physician that the Employee is disabled due to an Illness or Injury, the Plan will pay the Short-Term Disability benefit for which the Employee is eligible.

NOTE: An Employee will only receive Disability benefits if the Employee is Disabled. For example, if an Employee is on an FMLA-approved maternity leave, the leave would not qualify as Short-Term Disability unless the Employee was certified as Disabled by a Physician.

This benefit applies when an Employee has a Disability that meets all of the following requirements:

a. Disability starts while the Employee is covered for this benefit;

b. Employee's Disability is being continuously treated by a Physician; and

c. Disability is due to an Injury or Illness that, in either case, is non-occupational – that is, not arising from work for wage or profit.

The Plan Administrator reserves the option of requesting periodic physical examinations from either the current Physician on the case or a Physician of the Plan Administrator's choice. Failure to provide requested Physicians' statements will result in termination of benefits. The Employee is responsible for providing the following information in a clearly understandable format:

a. History regarding when symptoms first appeared or accident happened;

b. Diagnosis;

c. Dates of treatment;

d. Nature of treatment;

e. Progress;

f. Prognosis;

g. Suitability for rehabilitation; and

h. Physician's signature and tax I.D. number.

Additional information may be required based upon the Employee's Illness or Injury.

2. Benefit Payment

Payments will be made to the Employee and will continue until the earlier of the date the Employee has recovered or reached the benefit maximum. An Employee cannot collect Short Term Disability benefits simultaneously with sick or vacation pay.

Benefits are payable as outlined in the Schedule of Short Term Disability Benefits.

3. Extension of Benefits

If Medical and Prescription Drug coverage ends while the Employee is receiving Short-Term Disability benefit payments, Short Term Disability payments will continue until the earlier of the date the Employee recovers, reaches the benefit maximum or the date the Plan ends.

4. Occupational Disabilities

Short Term Disability benefits are not payable if Disability is due to an Illness or Injury that arises out of, incurred in or is connected with the course of any activity for wage or profit, for which the Employee would be entitled to benefits under (a) any workers' compensation, U.S. longshoreman and harbor work's or other occupational health law or policy, or (b) any exception or settlement made under such an occupational health law or policy (whether or not actually in force), or (c) expenses eligible for reimbursement under any other plan, program, insurance coverage, arrangement or the like.

5. Successive Periods of Disability

A "Period of Disability" is the period of time that an Employee is Disabled. Successive Periods of Disability due to the same or related causes will be considered one Period of Disability unless separated by return to Active Work for at least two consecutive weeks before the later Disability starts. Successive Periods of Disability due to entirely unrelated causes will be considered one period of Disability unless the later Disability starts after the Employee returns to Active Work. Only one benefit is paid for a Disability due to both an Illness and an Injury, or two or more concurrent Illnesses or Injuries.

Active Work means performing in the customary manner all of the regular duties of the Employee's occupation with an Employer, either at one of the Employer's regular places of business or at some location to which the Employer's business requires the Employee to travel to perform the Employee's regular duties or other duties assigned by the Employer.

6. Covered Weekly Earnings

Covered weekly earnings are the Employee's rate of weekly earnings from an Employer in effect on the later of:

a. The Employee's effective date of coverage under the Plan; or

b. The start of the Disability.

The following are not included in Covered Weekly Earnings:

a. Overtime pay;

b. Commissions; and

c. Bonuses.

7. Plan Limitations

Plan benefits will not be provided (as determined by the Employer):

a. If you become totally Disabled while you are on a paid vacation granted by your Employer, for any day of total Disability which occurs during such vacation;

b. If you retire or go on a paid leave of absence;

c. If you are Disabled due to an Injury or Illness related to any employment;

d. If you are Disabled due to an Injury or Illness covered under workers' compensation or similar law;

e. For any Disability in connection with the commission of a crime or in connection with war or act of war (declared or not);

f. An Injury or Illness sustained in the Armed Forces of any country engaged in war or other conflict;

g. An Injury or Illness for which a Covered Person is not treated by a Physician.

8. Coordination of Other Disability Income

Except as otherwise provided under the "Occupational Disabilities" section above, Disability benefits will be reduced by any Disability payments the Employee receives from the following sources:

a. Any plan, fund or other arrangement which provides benefits for loss of income from employment because of Disability, pursuant to any compulsory benefit act or law of any government.

b. Any plan, fund or other arrangement which the Employer has contributed to the cost or with respect to which the Employer has made payroll deductions, including, but not limited to, any pension or retirement plan.

c. Any motor vehicle reparations act of any government, but only to the extent of the basic reparations for loss of income provided without regard to fault under the act.

d. Any Social Security disability benefits.

e. Another employer's disability plan that the Employee is covered under, provided the Employee has been covered under that plan longer than the Employee has been covered under this Plan.

9. Plan Administrator Authority Under the Plan

The Plan Administrator will make all decisions necessary to administer the Plan, and any decision made by the Plan Administrator in connection with the Plan will be final and binding on all parties.

SECTION M. HEALTH REIMBURSEMENT ARRANGEMENT

1. General

The Plan has established a Health Reimbursement Arrangement (HRA) for active Bargained Employees and their eligible Dependents who are Plan Participants. Under the HRA an account funded by Employer contributions is maintained for each eligible Bargained Employee. You and your eligible Dependents can use this account to reimburse certain health care expenses up to the balance remaining in your account.

2. Eligibility

You are eligible to participate in the HRA if you are a Plan Participant and an active Bargained Employee covered by a collective bargaining agreement that provides for contributions to the HRA by your Employer. After an HRA account is established for you, you will continue to be eligible to receive Employer contributions to your account while you remain an active Bargained Employee. If you retire, terminate employment or no longer meet the hours of service or other eligibility requirements under the Plan, you may continue to request reimbursement of health care expenses that are covered by the HRA to the extent of any balance remaining in your HRA account, as discussed below. You may permanently opt out of the HRA and waive future reimbursements from your HRA account by submitting a written request to the Plan Administrator's office. Any balance remaining in the account will be transferred to the Plan Trust.

3. How the HRA Works

You may request reimbursement of certain health care expenses that you have paid out-of-pocket for yourself or any of your eligible Dependents who are Plan Participants, provided the expense is not covered by the Plan and is not eligible to be reimbursed from any other source (like another group health plan or an insurance policy). Among the health care expenses eligible for reimbursement under the HRA are the following:

a. Copayments, deductibles, and the portion of the coinsurance not paid by the Plan, as provided in the Schedule of Medical Benefits section of the Plan;

b. Self-payments by an eligible Retiree and surviving Dependents of a deceased eligible Bargained Employee or Retiree, as discussed in the Eligibility and Commencement of Coverage section of the Plan;

c. COBRA premium payments by an eligible Bargained Employee in connection with a Qualifying Event that is a reduction in hours or termination of employment of the Bargained Employee, and COBRA premium payments by surviving Dependents of a deceased eligible Bargained Employee in connection with a Qualifying Event that is the death of the deceased eligible Bargained Employee.

d. Dental vision and other health care expenses that meet the definition of medical care expenses under Section 213(d) of the Internal Revenue Code. Generally these are medical expenses that you are able to deduct on your income tax return. A complete list of medical expenses that are eligible for reimbursement can be found in the Internal Revenue Service's "Publication 502, Medical and Dental Expenses", which is provided at the IRS website, www.irs.gov, or for more information contact the IRS at 1-800-829-1040.

In order to qualify for reimbursement, the expense must be incurred by you or your eligible Dependent while covered and eligible to request reimbursement under the HRA. An expense is considered to be incurred on the date the supply is purchased or the service or treatment is received – not on the date that it is paid.

4. Applying for HRA Reimbursement

You may file a request for reimbursement from your HRA account up to two times per calendar year. You must have a minimum of $50 in covered health care expenses in order to file a reimbursement request. However, in the event your Plan coverage ends, you may submit covered health expenses totaling less than $50 in order to close out your HRA account. Otherwise, you should keep a record of your covered health care expenses that you and your Dependents incur until you and your Dependents reach $50 before submitting a request.

To apply for reimbursement, you must complete an HRA Reimbursement Form, which is available from the Plan Administrator's office:

Sheet Metal Workers Local Union 268
Welfare Plan
2701 North 89th Street
Caseyville, Illinois 62232
(618) 397-1443

In preparing the HRA Reimbursement Form, for each expense that you are requesting reimbursement you will need to provide the following information, as applicable:

a. The name of the person who received the health care;

b. A description of the health care treatment, service or supply and the date(s) on which the treatment, service or supply was received;

c. The amount of the requested reimbursement; and

d. A statement that the expense has not otherwise been reimbursed and is not reimbursable through any other source.

You also must attach to the HRA Reimbursement Form a copy of one or more of the following, as applicable:

a. An itemized bill from the service provider that includes the name of the person incurring the charges, date of service, description of services, name of the provider, and the amount of the charge;

b. An Explanation of Benefits (EOB) from the Plan when requesting reimbursement of the balance of charges that were not paid by the Plan, plus copies of receipts verifying that you paid the balance of charges;

c. Proof of the amount and date paid when requesting reimbursement for self-payments for continued coverage under the Plan;

d. A receipt and proof of purchase or rental of covered items (such as prescription drugs and medical supplies or equipment, like crutches or a wheelchair); and

e. Any additional documentation requested by the Plan Administrator.

It is recommended that you keep a copy of all paperwork that you submit for your records.

Claims for reimbursement must be submitted within 365 days of the expense in order to be eligible for reimbursement. Any claim submitted more than 365 days after the expense was incurred will be denied.

Requests for reimbursement will be processed within 30 days after the end of the month in which they are received. Upon approval of your application, you will be reimbursed up to the balance in your HRA account. If your claim for reimbursement is denied, you may appeal that decision in accordance with the Claims Review and Appeal Procedures section of the Plan.

If you do not use the entire balance of your HRA account during the calendar year, the unused portion will be carried over for you to use in the following years for as long as you remain eligible to make withdrawals from your HRA account.

It is recommended that you keep a copy of all paperwork that you submit for your records.

5. Disposition of HRA Account if Plan Coverage Terminates as an Active Employee

If you are no longer eligible for coverage under the Plan because you have not worked enough hours to maintain your eligibility, you will have the option to continue your medical coverage by electing COBRA continuation coverage and making self-payments under the Plan, as more fully discussed in the COBRA Continuation Coverage section of the Plan. If you elect COBRA, you can use the money in your HRA account to pay the required contributions or other eligible health care expenses until your HRA account is exhausted.

Additionally, if you retire with an HRA account balance and you meet the eligibility requirements for Retiree coverage under the Plan, as discussed in the Eligibility and Commencement of Coverage section of the Plan, you can use your HRA account balance to pay the required contributions for your Retiree coverage and other eligible health care expenses until your HRA account is exhausted.

In the event that an eligible active Bargained Employee or Retiree dies with a balance in the individual's HRA account, that balance will be made available to the Bargained Employee's or Retiree's surviving eligible Dependents who are Plan Participants at the time of the Bargained Employee's or Retiree's death. The surviving eligible Dependents can then request reimbursement for payments made to continue their Plan coverage (as discussed in the Eligibility and Commencement of Coverage section of the Plan) and for other eligible health care expenses, in the same manner as for the Employee or Retiree.

In addition to the eligible health care expenses listed under the "How the HRA Works" section above, surviving Dependents can also submit premiums, copayments, deductibles and the coinsurance balances that eligible Dependent incurs under another group health plan or group insurance policy through which the eligible Dependent has health care coverage provided such group plan or policy meets the minimum value standards set forth in the Patient Protection and Affordable Care Act and applicable regulations.

Surviving eligible Dependents may also permanently opt out of the HRA and waive future reimbursements from the HRA account. If the surviving eligible Dependents have not opted out of the HRA and they do not exhaust the balance of the HRA account within 60 months after the death of the Bargained Employee or Retiree, the remaining balance will be forfeited and transferred to the Plan Trust.

In the event the deceased Bargained Employee or Retiree does not have any surviving eligible Dependents who are Plan Participants at the time of the Bargained Employee's or Retiree's death, the Bargained Employee's or Retiree's HRA account balance will be forfeited and transferred to the Plan Trust.

If you are no longer covered under the Plan but have a balance remaining in your HRA account, you can use the money to pay for eligible health care expenses that you or your eligible Dependents incur after the date your Plan coverage terminates. In addition to the eligible health care expenses listed under the "How the HRA Works" section above, you can also submit premiums, copayments, deductibles and the coinsurance balances that you or your eligible Dependents incur under another group health plan or group insurance policy through which you or your eligible Dependent has health care coverage provided such group plan or policy meets the minimum value standards set forth in the Patient Protection and Affordable Care Act and applicable regulations. You or, in the event of your death, your surviving eligible Dependents may also permanently opt out of the HRA and waive future reimbursements from the HRA account. If you or your surviving Dependents have not opted out of the HRA and you (or they) do not exhaust the balance of the HRA account within 60 months after the date your Plan coverage terminates, the remaining balance will be forfeited and transferred to the Plan Trust.

Please note, however, if you withdraw from the Sheet Metal Workers International Association Local 268 and terminate your coverage under the Plan, you will immediately forfeit the right to spend down your HRA account. If you withdraw from the Sheet Metal Workers International Association Local 268 and continue to participate in the Plan, you or, in the event of your death, your surviving eligible Dependents may continue to spend down your HRA account for up to 6 months following the date of your withdrawal. You cannot withdraw your HRA account balance as a lump sum cash out at the time you terminate coverage under the Plan.

In addition to the above, Plan Participants who are participating in the HRA and incur a COBRA qualifying event can elect COBRA for their HRA coverage

in accordance with the procedures described in the COBRA Continuation Coverage section of the Plan. In order to continue HRA coverage under COBRA, a Plan Participant is required to make monthly contributions to the HRA account to cover the cost of the continued HRA coverage.

6. HRA Administration

The HRA is administered by the Plan Administrator. Call the Plan Administrator's office at (618) 397-1443 if you have any questions or need more information about your HRA benefit.

SECTION N. FILING A CLAIM

1. How To Submit A Claim

a. Claims for Medical Benefits

Generally, you will not be required to submit a claim for medical benefits. Your Physician, Hospital or other provider will forward the bills to Meritain Health. Receipt of such bills will be regarded as receipt of a claim. In some circumstances, you will be contacted for additional information. You should provide any such information as soon as possible after requested.

If you pay a provider directly, you can file a claim for reimbursement. You can obtain claim forms from the Meritain Health website at www.Meritain.com or by calling Meritain Health at 1-866-209-3400. You will need to attach bills for the services that were provided to you. Documentation for your claim must include the following:

(1) Name of the Plan;

(2) Employee's or Retiree's name;

(3) Name of patient;

(4) Name, address, telephone number and federal tax identification number of the provider of care;

(5) Diagnosis;

(6) Type of services rendered, with diagnosis and/or procedure codes;

(7) Date of service;

(8) Charges; and

(9) If another plan is the primary payor, a copy of the other plan's Explanation of Benefits (EOB) must accompany the claim form.

Mail the completed claim form and attached documentation to the Claims Processing Office at the address listed below:

Meritain Health
PO Box 853921
Richardson, TX 75085-3921

Questions regarding the claim can be addressed by calling the following toll-free number:

1-866-209-3400

b. Claims for Prescription Drug Benefits

Typically it is not necessary to file a claim for Prescription Drug benefits. You simply present your prescription along with you I.D. card to a participating Pharmacy and you will be provided with your medication.

If for any reason you have not used the Prescription Drug card or you are denied a Prescription Drug or believe you were charged too much for the Prescription Drug or used a non-participating Pharmacy, you may file a claim for Prescription Drug benefits with Citizens Rx. You must obtain a Prescription Drug claim direct reimbursement form from the Plan Administrator's office, attach the receipt and any other supporting documentation, and submit the claim to the Prescription Drug Program administrator at the following address:

Citizens Rx
1144 Lake Street
Oak Park, Illinois 60301

c. Short-Term Disability Benefits

You must obtain a claim form for Short Term disability benefits from the Plan Administrator's office. The form must be completed by you, your Employer, and your Physician and returned to the Plan Administrator's office. The completed claim form should be accompanied by all supporting documentation.

2. Additional Information and Physical Examination

The Plan has the right to require the submission of additional information regarding a claim for benefits. The Plan further reserves the right, at its own expense, to require the medical examination of any individual whose Injury or Illness is the basis for a claim under the Plan when and as often as the Plan may reasonably require during the duration of the condition for which the claim is made, including making an autopsy in case of death where permitted by law.

3. When Claims Must be Submitted

You must submit a claim for medical and Prescription Drug benefits within 365 days of the date the service was incurred. For Short Term Disability benefits you must submit a completed claim form no later than 365 days after the date the Disability commenced. Benefits are based on the Plan's provisions at the time the expenses were incurred or the Disability commenced and are subject to change in accordance with the applicable law

and the terms of the Plan. Claims filed more than 365 days after the date the service was incurred or the Disability commenced will be declined.

SECTION O. CLAIMS REVIEW AND APPEAL PROCEDURES

1. Generally

The Plan's claims review and appeal procedures are intended to reflect the Department of Labor's claims procedure regulations, and should be interpreted accordingly. In the event of any conflict between this Plan Document and the Department of Labor regulations, the regulations will control. In addition, any applicable changes in the Department of Labor regulations shall be deemed to amend this Plan document automatically, effective as of the date of those changes.

To receive benefits under the Plan, the claimant must follow the procedures established by the benefit administrator that has responsibility for the particular benefit involved.

Decisions on claims and appeals are uniformly made in accordance with the terms and conditions of the Plan and cannot be paid unless authorized by the Plan.

2. Medical and Prescription Drug Benefit Claims

a. Initial Claim Determination

(1) **Urgent Care Claims.** If the claimant's health benefit claim is an urgent care claim, the reviewer will notify the claimant of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the reviewer will notify the claimant as soon as possible, but not later than 24 hours after receipt of the urgent care claim by the Plan, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by the claimant. The claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The reviewer will notify the claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (a) the Plan's receipt of the specified additional information, or (b) the end of the period afforded the claimant to provide the specified

information. If the determination is adverse to the claimant, the notice will contain the information described in Subsection (6) below.

A health benefit claim is considered an urgent care claim if the application of the time periods for making a non-urgent care claim determination could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim.

(2) **Concurrent Care Claims.** If the Plan has approved a concurrent or ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by the Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse benefit determination. In such a case, the reviewer will notify the claimant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before reduction or termination of the benefit. The notice of the adverse benefit determination will contain the information described in Subsection (6) below.

Any request by a claimant to extend a previously approved concurrent or ongoing course of treatment involving an urgent care claim beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies, and the reviewer will notify the claimant of the benefit determination, whether adverse or not, within twenty-four (24) hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments. If the determination is adverse to the claimant, the notice will contain the information described in Subsection (6) below.

(3) **Pre-Service Claim.** In the case of a pre-service health benefit claim, the reviewer will notify the claimant of the benefit determination (whether adverse or not) within a reasonable period of time

appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. If, due to matters beyond the control of the Plan, the reviewer needs additional time to process the claim, the reviewer may extend the time for notifying the claimant of the Plan's benefit determination for up to 15 days, provided that within 15 days after the Plan receives the claim the reviewer notifies the claimant of those special circumstances and when the reviewer expects to make its decision. However, if such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information, and the claimant will be afforded at least 45 days from receipt of the notice to provide the specified information.

A health benefit claim is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

(4) **Post-Service Health Benefit Claim.** In the case of a post-service health benefit claim, the reviewer will notify the claimant of the adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the reviewer needs additional time to process a claim, the reviewer may extend the time for notifying the claimant of the Plan's benefit determination on a one-time basis for up to 15 days, provided that within 30 days after the Plan receives the claim the reviewer notifies the claimant of those special circumstances and the date by which the reviewer expects to make a decision. However, if such a decision is necessary due to the failure of the claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the claimant will be afforded at least 45 days from receipt of the notice to provide the specified information.

A health benefit claim is considered a post-service claim if it is a request for payment of services which the claimant has already received.

(5) **Calculation of Time Periods.** For purposes of these time periods relating to the Plan's initial benefit determination, the period of time during which an initial benefit determination is required to be made begins at the time a claim is filed in accordance with the Plan procedures without regard to whether all the information necessary

to make a decision accompanies the request. If a period of time is extended due to a claimant's failure to submit all information necessary, the period for making the determination is "frozen" from the date the notification is sent to the claimant until the date the claimant responds to the request for additional information.

(6) Manner and Content of Notice of Denial of Initial Claim. If the reviewer denies a claim, it must provide to the claimant, in writing or by electronic communication, a notice stating:

(a) The specific reason(s) for the denial;

(b) Reference to the specific Plan provision(s) on which the denial is based;

(c) A description of any additional information or material that the claimant must provide in order to perfect the claim, and an explanation of why the additional material or information is necessary;

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

(e) A copy of any rule, guidelines, protocol or other similar criterion relied upon in making the adverse benefit determination (or a statement that such rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, and that a copy of such rule, guideline, protocol or other similar criterion will be provided to the claimant upon request and without charge);

(f) If the adverse benefit determination is based on the Medical Necessity standard, that the treatment is Experimental or Investigational or a similar exclusion or limit, either: (i) an explanation of the scientific or clinical judgment applying the exclusion or limit to the claimant's medical circumstances; or (ii) a statement that the same will be provided to the claimant upon request and without charge;

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

(h) In the case of an adverse benefit determination concerning a health benefit claim involving urgent care, a description of the expedited review process applicable to such claim.

NOTE: The information described in this section with regard to an urgent care claim may be provided to the claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with this Section is furnished to the claimant no later than 3 days after the oral notification.

b. Appeal of Initially Denied Claim

If a claimant submits a claim for Plan benefits and it is initially denied under the procedures described above, the claimant may appeal and request a review of that denial under the following procedures.

(1) Filing Request for Review of Denied Claim. A claimant for health benefits has one hundred eighty (180) days following receipt of a notification of an adverse initial benefit determination within which to request a review of the adverse initial benefit determination. In such cases, the review will meet the following requirements:

(a) The Plan will provide a review that does not afford deference to the adverse initial benefit determination and that is conducted by an appropriate named fiduciary of the Plan who did not make the adverse initial benefit determination that is the subject of the appeal, nor is a subordinate of the individual who made the adverse initial determination.

(b) The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse initial benefit determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental, Investigational or not Medically Necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence shall be an individual who was neither an individual who was consulted in connection with the adverse initial benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

(c) The Plan will identify to the claimant the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse initial benefit determination, without regard to whether the advice was relied upon in making the adverse initial benefit determination.

(d) In the case of a requested review of an adverse initial benefit determination of an urgent care claim, the review process shall meet the expedited deadlines described below. The claimant's request for such an expedited review may be submitted orally or in writing by the claimant and all necessary information, including the Plan's determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile or other available similarly expeditious method.

(e) The reviewer will afford the claimant an opportunity to review and receive, without charge, all relevant documents, information and records relating to the claim for benefits and to submit issues and comments relating to the claim for benefits in writing to the Plan Administrator. The reviewer will take into account all comments, documents, records and other information submitted by the claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

(f) If the determination on review is adverse to the claimant, the claimant will receive a notice containing the information described in Subsection (3) below.

All requests for review of initially denied urgent care claims, concurrent care claims and pre-service claims (including all relevant information) must be submitted to the following address:

Meritain Health, Inc.
Appeals Department
PO Box 1380
Amherst, NY 14226-1380

All requests for review of initially denied post-service claims (including all relevant information) must be submitted to the following address:

(2) Deadline for Review Decisions.

(a) Urgent Care Claim. In the case of a request for review of the denial of an urgent care claim, the reviewer will notify the claimant of the determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of the adverse initial benefit determination by the Plan.

(b) Concurrent Care Claim. In the case of a request for review of a determination by the Plan to reduce or terminate a previously approved concurrent or ongoing course of health care treatment to be provided over a period of time or number of treatments, the reviewer will notify the claimant of the determination, whether adverse or not, on review before the reduction or termination of the benefit, if the claimant files an appeal that allows for sufficient time to conduct the review. In all other cases, the reviewer will notify the claimant of the determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after receipt by the Plan of the claimant's request for review of the adverse initial benefit determination. The reviewer's decision on the appeal is final and not subject to further review.

If the claimant is appealing an adverse determination in response to the claimant's request to extend a previously approved concurrent or ongoing course of treatment involving an urgent care claim beyond the approved period of time or number of treatments, the reviewer will notify the claimant of the Plan's determination on review, whether adverse or not, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review. The reviewer's decision on the appeal is final and not subject to further review.

(c) Pre-Service Claim. In the case of a request for review of the denial of a pre-service health benefit claim, the reviewer will

notify the claimant of the determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after receipt by the Plan of the claimant's request for review of the adverse initial benefit determination. The reviewer's decision on the appeal is final and not subject to further review.

(d) Post-Service Claim. A benefit determination on appeal of a post-service health benefit claim is made by the Board of Trustees of the Sheet Metal Workers Local Union 268 Welfare Plan. The benefit determination will be made by no later than the date of the next meeting of the Board of Trustees after the Plan receives a request for review, unless the request is filed within 30 days before that meeting, in which case the benefit determination will be made by no later than the date of the second meeting after the Plan receives the request. If special circumstances (such as the need to hold a hearing, if the Plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination will be rendered not later than the third meeting of the Board of Trustees following the Plan's receipt of the request for review. The Plan will notify the claimant in writing if such an extension is needed, describing the special circumstances and the date by which the benefit determination will be made, prior to the commencement of the extension. The Plan will notify the claimant of the benefit determination as soon as possible, but no later than five (5) days after the benefit determination is made. The Board of Trustees decision on the appeal is final and not subject to further review.

(e) Calculation of Time Periods. For purposes of the time periods specified in this section, the period of time during which a benefit determination on review is required to be made begins at the time the appeal and request for review of an adverse initial benefit determination is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a benefit determination or review accompanies the request for review. If a period of time is extended due to a claimant's failure to submit all information necessary, the period for making the determination shall be "frozen" from the date the notification requesting the

additional information is sent to the claimant until the date the claimant responds to the request for additional information.

(3) Manner and Content of Notice of Decision on Review. Upon completion of its review of an adverse initial benefit determination, the reviewer will give the claimant, in writing or by electronic communication, a notice containing the reviewer's decision. If the reviewer reaches an adverse benefit determination, the notice must include:

(a) The specific reason(s) for the adverse determination;

(b) Reference to the specific Plan provision(s) on which the adverse determination is based;

(c) A statement that the claimant is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to the claimant's claim for benefits;

(d) A statement describing the claimant's right to bring an action for judicial review under ERISA Section 502(a);

(e) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that such rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, and that a copy of such rule, guideline, protocol or other similar criterion will be provided to the claimant upon request and without charge;

(f) If the adverse determination on review is based on the Medical Necessity standard, that the treatment is Experimental or Investigational or a similar exclusion or limit, either: (i) an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the claimant's medical circumstances; or (ii) a statement that such an explanation will be provided to the claimant upon request and without charge; and

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

benefit is an insured benefit, your State insurance regulatory agency."

c. External Review Procedure for Adverse Determination Related to Surprise Billing and Cost Sharing

(1) Deadline for External Review

The claimant may file a request for external review within four months after the date the claimant receives notice of an adverse benefit determination or final adverse internal appeal determination involving the Plan's compliance with the surprise billing and cost-sharing protections of the No Surprises Act with respect to Emergency Services, Non-Emergency Services provided by a Non-Network Provider at a Network facility, and/or air ambulance services.

The claimant's request for an external review should be sent to the Fund Office unless the claimant is specifically instructed otherwise in the appeal determination notice that is sent to the claimant. If there is no corresponding date four months after the date of receipt of the notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date falls on a Saturday, Sunday, or Federal holiday, the filing deadline is extended to the next day that is not a Saturday, Sunday or Federal holiday.

(2) Preliminary Review

Within five business days following receipt of the claimant's request for an external review, the Plan will complete a preliminary review of the request to determine whether the claimant is or was covered under the Plan at the time the healthcare item, service or other benefit was requested or, in the case of a retrospective review, was covered under the Plan at the time the healthcare item, service or other benefit was provided;

(a) the adverse benefit determination or final adverse internal appeal determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan;

(b) the claimant has exhausted the Plan's internal appeal process, unless the claimant is not required to exhaust the internal appeal process under the federal interim final regulations (which involved certain limited exceptional circumstances); and

(c) the claimant has provided all of the information and forms required to process an external review.

(3) Notice of Preliminary Review

Within one business day after completion of the initial review, the Plan will issue the claimant a notice in writing regarding the claimant's eligibility for external review. If the claimant's request for external review is complete but not eligible for external review, the notice will include the reasons for the request's ineligibility and contact information for the Employee Benefits Security Administration (toll-free 866-444-3272). If the claimant's request for external review is not complete, the notice will describe the information or materials needed to make the request complete and the claimant will be allowed to perfect the claimant's request for external review within the four-month filing period or within the 48-hour period following the claimant's receipt of the notice, whichever is later.

(4) Review by Independent Review Organization

(a) If the claimant's request for external review is eligible for submission to an Independent Review Organization (IRO), the Plan will assign the claimant's request for external review to an IRO to evaluate the claimant's eligibility for external review and will conduct the external review in accordance with procedures established under federal law. The IRO will be assigned in accordance with the Plan's rules, which provide an assignment or rotation method that ensures independence and against a bias towards the Plan. The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits.

(b) Upon receipt of the claimant's request for external review, the IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the claimant may submit in writing to the assigned IRO within 10 business days following the date the claimant receives this notice additional information that the IRO

will consider when conducting the external review. The IRO may, but is not required to, accept and consider additional information submitted after 10 business days.

(c) Within five business days after the date of assignment to the IRO, the Plan will provide to the IRO any documents and any information considered in making the adverse benefit determination or final adverse internal appeal determination. Failure by the Plan to provide documents cannot delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or the final adverse internal appeal determination. Within one business day after making the decision, the IRO will notify the claimant and the Plan.

(d) The IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.

(e) The IRO will review all information and documents timely received. In reaching a decision, the IRO will review the claim *de novo* (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO must observe the terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO must also observe the Plan's applicable standards for clinical review criteria, including Medical Necessity, appropriateness, healthcare setting, level of care and effectiveness of a covered benefit, unless the criteria are inconsistent with the terms of the Plan or with applicable law. In addition to the documents and information provided, the assigned IRO will consider the following, to the extent available and to the extent the IRO considers them appropriate, in reaching an external review decision:

- the claimant's medical records;
- the attending healthcare professional's recommendation;
- reports from appropriate healthcare professionals and other documents submitted by the Plan, the claimant or the claimant's treating healthcare provider;

- appropriate medical practice guidelines, including evidence-based standards; and
- the opinion of the IRO's clinical reviewer or reviewers based on the documents and information provided and to the extent the clinical reviewer or reviewers consider those documents and information appropriate.

(f) The IRO will provide written notice of the final external review decision to the claimant and the Plan within 45 days after the IRO receives the request for external review. The IRO's external review decision will contain:

- a general description of the reason for the request for external review, including, where applicable, information sufficient to identify the claim (including the date or dates of service, the healthcare provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
- the date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- references to the evidence or documentation, including the specific coverage provisions and evidence-based standards that were considered in reaching the IRO's decision;
- a discussion of the principal reason or reasons for the IRO's decision, including the rationale for the decision and any evidence-based standards that were relied on in making the decision;
- a statement that the determination is binding except to the extent that other remedies may be available under state or Federal law, as applicable, to either the Plan or to the claimant;
- a statement that judicial review may be available to the claimant; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Public

Health Services Act Section 2793 to assist individuals with the external review processes.

(5) After External Review

Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final adverse internal appeal determination, the Plan will provide coverage or payment for the claim, including authorizing or paying benefits, as soon as possible in accordance with applicable law. The Plan reserves the right to pursue judicial review or other remedies available or that may become available to the Plan under applicable law. The Plan will provide benefits (including making payment on the claim) without delay pursuant to a final external review decision in the claimant's favor, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

If the final external review upholds the Plan's adverse benefit determination or final adverse internal appeal determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If the claimant is dissatisfied with the external review determination, the claimant may seek judicial review as permitted under ERISA Section 502(a) and subject to the limitation described in Section E. above.

The external review standards provide that an external review decision is binding on the Plan, as well as on the claimant, except to the extent other remedies are available under state or Federal law.

(6) IRO Maintenance of External Review Records

After a final external review decision, the IRO will maintain records of all claims and notices associated with the external review process for a minimum of six years. An IRO will make such records available for examination by the claimant, the Plan, or state or Federal government oversight agency upon request, except where such disclosure would violate state or Federal privacy laws.

3. Disability Benefit Claims

a. Initial Claim Determination

(1) Time Period for Initial Claim Decision. The Plan will evaluate and make a decision with respect to a claim for disability benefits within

45 days after the claimant submits the claim. This 45-day limit may be extended twice by up to 30 days each time. The reviewer will, prior to the expiration of the original 45-day period, or first 30-day extension, notify the claimant of the reason for the delay and the date by which a decision can be expected. The reviewer will also explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision, and the additional information needed to resolve the claim.

The claimant will be given 45 days to provide such additional information. If a period of time is extended due to a claimant's failure to submit all information necessary, the period for making the determination is "frozen" from the date the notification is sent to the claimant until the date the claimant responds to the request for additional information. (The Plan's time limits are tolled while the Plan is waiting for the claimant to provide additional information.)

(2) Manner and Content of Notice of Denial of Initial Claim. If the reviewer denies a claim, it must provide to the claimant, in writing or by electronic communication:

(a) The specific reason(s) for the denial;

(b) A reference to the Plan provision(s) on which the denial is based;

(c) A description of any additional information or material that the claimant must provide in order to perfect the claim, and an explanation of why the additional material or information is necessary;

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

(e) A copy of any rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination (or a statement that such rule, guideline, protocol or other similar criterion does not exist;

(f) If the adverse benefit determination is based on a medical opinion, either: (i) an explanation of the scientific or clinical judgment applying the exclusion or limit to the claimant's

medical circumstances; or (ii) a statement that the same will be provided to the claimant upon request and without charge; and

(g) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits.

(h) An explanation of the reviewer's basis for disagreeing with or not following:

- the views presented by the claimant of the healthcare and/or vocational professionals who treated or evaluated the claimant;
- the views of medical or vocational experts whose advice was obtained by the reviewer in connection with the claimant's claim for benefits, without regard to whether the advice was relied upon; and
- a disability determination regarding the claimant by the Social Security Administration.

b. Appeal of Initially Denied Claim

If a claimant submits a claim for Plan benefits and it is initially denied under the procedures described above, the claimant may appeal and request a review of that denial under the following procedures.

(1) Filing Request for Review of Denied Claim. A claimant for health benefits has one hundred eighty (180) days following receipt of a notification of an adverse initial benefit determination within which to appeal and request a review of the adverse initial benefit determination. In such cases, the review will meet the following requirements:

(a) The Plan will provide a review that does not afford deference to the adverse initial benefit determination and that is conducted by an appropriate named fiduciary of the Plan who did not make the adverse initial benefit determination that is the subject of the appeal, nor is a subordinate of the individual who made the adverse initial determination.

(b) The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical

judgment before making a decision on review of any adverse initial benefit determination based in whole or in part on a medical judgment. The professional engaged for purposes of a consultation in the preceding sentence shall be an individual who was neither an individual who was consulted in connection with the adverse initial benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

(c) The Plan will identify to the claimant the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse initial benefit determination, without regard to whether the advice was relied upon in making the adverse initial benefit determination.

(d) The reviewer will afford the claimant an opportunity to review and receive, without charge, all relevant documents, information and records relating to the claim for benefits and to submit issues and comments relating to the claim for benefits in writing to the Plan Administrator. The reviewer will take into account all comments, documents, records and other information submitted by the claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

(e) If the reviewer will rely on new or additional evidence or on new or additional rationales in issuing an adverse determination on appeal, the reviewer will notify the claimant sufficiently in advance of the determination on appeal to allow the claimant a reasonable opportunity to respond.

All requests for review of initially denied claims (including all relevant information) must be submitted to the following address:

Board of Trustees of the Sheet Metal Workers
Local Union 268 Welfare Plan
2701 North 89th Street
Caseyville, Illinois 62232

(2) Deadline for Review Decisions. A benefit determination on appeal is made by the Board of Trustees of the Sheet Metal Workers Local Union 268 Welfare Plan. The benefit determination will be made by no later than the date of the next meeting of the Board of Trustees after the Plan receives a request for review, unless the request is filed within 30 days before that meeting, in which case the benefit

determination will be made by no later than the date of the second meeting after the Plan receives the request. If special circumstances (such as the need to hold a hearing, if the Plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination will be rendered not later than the third meeting of the Board of Trustees following the Plan's receipt of the request for review. The Plan will notify the claimant in writing if such an extension is needed, describing the special circumstances and the date by which the benefit determination will be made, prior to the commencement of the extension. The Plan will notify the claimant of the benefit determination as soon as possible, but no later than five (5) days after the benefit determination is made.

(3) Calculation of Time Periods. For purposes of the time periods specified in this section, the period of time during which a benefit determination on review is required to be made begins at the time that the appeal and request for review of an adverse initial benefit determination is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a benefit determination or review accompanies the request for review. If a period of time is extended due to a claimant's failure to submit all information necessary, the period for making the determination shall be "frozen" from the date the notification requesting the additional information is sent to the claimant until the date the claimant responds to the request for additional information.

(4) Manner and Content of Notice of Decision on Review. Upon completion of its review of an adverse initial benefit determination, the reviewer will give the claimant, in writing or by electronic communication, a notice containing the reviewer's decision. If the reviewer reaches an adverse benefit determination, the notice must include:

(a) The specific reason(s) for the decision;

(b) Reference to the relevant Plan provision(s) on which the adverse determination is based;

(c) A statement that the claimant is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to the claimant's claim for benefits;

(d) A statement describing the claimant's right to bring an action for judicial review under ERISA Section 502(a), describing any contractual limitations on that right as well as the calendar date on which that right will expire;

(e) A copy of any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination (or a statement that such rule, guideline, protocol or other similar criterion does not exist);

(f) If the adverse determination on review is based on a medical opinion, either: (i) an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the claimant's medical circumstances, or (ii) a statement that such an explanation will be provided to the claimant upon request and without charge; and

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

(h) An explanation of the reviewer's basis for disagreeing with or not following:

- the views presented by the claimant of the healthcare and/or vocational professionals who treated or evaluated the claimant;
- the views of medical or vocational experts whose advice was obtained by the reviewer in connection with the claimant's claim for benefits, without regard to whether the advice was relied upon; and
- a disability determination regarding the claimant by the Social Security Administration.

4. Statute of Limitations for Plan Claims

No legal action may be commenced or maintained to recover benefits under the Plan more than 365 days after the final review or appeal decision by the Plan has been rendered (or deemed rendered). Before bringing such an action the claimant must exhaust the Plan's claims review and appeal procedures.

5. Designation of Representative

A claimant may designate another person to act as the claimant's authorized representative for purposes of the Plan's claims review and appeal procedures. To designate an authorized representative the claimant will need to fill out a form, which may be obtained from the Plan Administrator's office.

SECTION P. COORDINATION OF BENEFITS

1. Coordination of Benefit Plans

Coordination of benefits is the order of payment when charges are eligible under two or more benefit plans. Coordination of benefits also occurs when the Covered Person is covered by the Plan and Medicare.

The plan that pays first according to the rules will pay as if there was no other coverage. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable expenses.

2. Benefit Plan

This Plan will coordinate the medical benefits with the following Benefit Plans:

a. Group blanket or franchise insurance coverage;

b. Any group Hospital service prepayment, group medical or dental service prepayment, group practice or other group prepayment coverage;

c. Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, school insurance or employee benefit organization plans;

d. Coverage under Medicare and any other governmental program that the covered Person is liable for payment, except state-sponsored medical assistance programs and TRICARE, in which case this Plan pays primary;

e. Coverage under any Health Maintenance Organization (HMO); or

f. Any mandatory automobile insurance (such as no-fault) providing benefits under a medical expense reimbursement provision for health care services because of Injuries arising out of a motor vehicle accident and any other medical and liability benefits received under any automobile policy.

3. Allowable Charge

This Plan will consider only covered charges under this Plan as Allowable Charges.

In the case of HMO or other in-network only plans, this Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan

will not consider as an allowable charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of "service type plans" where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

4. No-Fault Auto Insurance Limitations

When medical payments are available under vehicle insurance, this Plan will pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan will always be considered secondary and coordinate with benefits provided or required by any no-fault insurance statute whether or not a no-fault policy is in effect.

5. Benefit Plan Payment Order

When two or more Benefit Plans provide benefits for the same Allowable Charge, benefit payment will follow these rules.

a. Benefit Plans that do not have a coordination of benefits provision will pay first.

b. Benefit Plans with a coordination of benefits provision will pay benefits up to the Allowable Charge as follows:

(1) The Benefit Plan which covers the person directly (that is, as an employee, member or subscriber) will determine benefits thereunder before benefits are considered under a Benefit Plan which covers the person as a dependent.

However, when a person is covered as the dependent of the person's spouse who is actively employed and is also covered as a retiree or former employee, the Medicare law provides that Medicare is primary to the Benefit Plan that covers the person as other than a dependent and secondary to the Benefit Plan that covers the person as a dependent. In such circumstances, the Benefit Plan that covers the person as a dependent pays first, Medicare pays second, and the Benefit Plan that covers the person as other than a dependent pays last.

(2) The Benefit Plan which covers a person as an employee who is neither laid-off nor retired will determine benefits before a Benefit Plan which covers that person as a laid-off or retired employee. The Benefit Plan which covers a person as a dependent of an employee who is neither laid-off nor retired will determine benefits

thereunder before benefits are considered under a Benefit Plan which covers a person as a dependent of a laid-off or retired employee. If the other Benefit Plan does not have this rule, and if, as a result, the Benefit Plans do not agree on the order of benefits, this rule does not apply.

(3) The Benefit Plan which covers a person as an employee who is neither laid-off nor retired or a dependent of an employee who is neither laid-off nor retired will determine benefits before benefits are considered under a Benefit Plan which covers the person as a COBRA beneficiary.

(4) When a child is covered as a dependent and the parents are not separated or divorced, the following rules will apply:

(a) The Benefit Plan of the parent whose birthday falls earlier in a year will determine benefits before benefits are considered under a Benefit Plan of the parent whose birthday falls later in that year;

(b) If both parents have the same birthday, the Benefit Plan which has covered the child for the longer period of time will determine benefits before benefits are considered under the Benefit Plan which covers the other parent.

(5) When a child's parents are divorced or legally separated, the following rules will apply:

(a) This rule applies when the parent with custody of the child has not remarried. The Benefit plan of the parent with custody will determine benefits before benefits are considered under the Benefit Plan of the parent without custody.

(b) This rule applies when the parent with custody of the child has remarried. First, the Benefit Plan of the parent with custody will determine benefits. Next, the Benefit Plan of the stepparent that covers the child as a dependent will determine benefits. Finally, the Benefit Plan of the parent without custody will determine benefits.

(c) This rule will be in place of items (a) and (b) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the Benefit Plan of that parent will determine benefits

before benefits are considered under other Benefit Plans that cover the child as a dependent.

(d) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Benefit Plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a dependent and the parents are not separated or divorced.

(6) When a child's parents were never married to each other, the rules as set out above in subsection (6) will apply as long as paternity has been established.

(7) If there is still a conflict after these rules have been applied, the Benefit Plan which has covered the patient for the longer period of time will determine benefits thereunder first. When there is a conflict in coordination of benefit rules, this Plan will never pay more than 50% of Allowable Charges when paying secondary.

(8) When a married (adult) child is covered under a Benefit Plan as a dependent child through his or her parent(s) and is covered by another Benefit Plan as a dependent spouse, the Benefit Plan that covers the child as a dependent spouse will determine benefits before the Benefit Plan that covers the child as a dependent of the child's parent(s),

c. Medicare will pay primary, secondary or last, as specified in applicable law.

When Medicare is the primary payer, this Plan will base its payment upon benefits allowable by Medicare. If the Covered Person did not enroll for coverage under Medicare Parts A and B when eligible, this Plan will be secondary and coordinate with benefits that would have been provided by Medicare as if the Covered Person had enrolled for coverage under Medicare Parts A and B.

d. If a Covered Person is under a disability extension from a previous Benefit Plan, that Benefit Plan will pay first and this Plan will pay second.

6. Effect of Medicare

In accordance with federal law, the following is a brief explanation of the Medicare guidelines and should not be considered all inclusive.

When a covered Employee, Retiree or Spouse of an Employee or Retiree reaches age 65, the Covered Person may become eligible for Medicare based on the Covered Person's age. A covered Employee, Retiree or Dependent of a covered Employee or Retiree may also become eligible for Medicare prior to age 65 due to disability or End Stage Renal Disease (ESRD).

This Plan will pay benefits before Medicare:

a. For an age 65 or older covered Employee or an age 65 or older covered Spouse of a covered Employee;

b. For a covered Employee or a covered Dependent of a covered Employee who is eligible for Medicare under age 65 due to disability; or

c. For the first 30 months a covered Employee or Retiree or a covered Dependent of a covered Employee or Retiree is eligible for Medicare due to ESRD (or 33 months, depending upon whether a transplant or self-dialysis is involved).

This Plan will pay benefits after Medicare:

a. For a covered former Employee, Retiree or Spouse of a covered former Employee or Retiree who is age 65 or older; or

b. After the first 30 months a covered Employee, Retiree or Dependent of a covered Employee or Retiree is eligible for Medicare due to ESRD (or 33 months, depending upon whether a transplant or self-dialysis is involved).

SECTION Q. ASSIGNMENT AND OTHER BENEFIT PAYMENT PROVISIONS

1. Assignment of Benefits

No benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, bankruptcy, pledge, encumbrance or charge, and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

Further, no Covered Person has the right to anticipate, alienate, sell, transfer, pledge, assign or otherwise encumber any right (legal, equitable or otherwise) to which such Covered Person is entitled by virtue of coverage under the Plan, including but not limited to requesting documents or filing any court proceeding.

All or a portion of benefits payable under the Plan may be, at the Plan Administrator's option, paid directly to the Hospital or provider that rendered the services being claimed. The Plan's direct payment does not validate any attempted assignment or other action prohibited under this section.

Notwithstanding the foregoing, the Plan will provide benefits as required under the terms of a Qualified Medical Child Support Order ("QMCSO") which provides for coverage under the Plan for a Child Dependent who is an alternate recipient, in accordance with the requirements of ERISA and the Plan's QMCSO procedures.

2. Inability to Locate Recipient of Benefit Payment

If the Plan Administrator is unable to make payment to any Covered Person or other person to whom a payment is due under the Plan because the Plan Administrator cannot ascertain the identity or whereabouts of such Covered Person or other person after reasonable efforts have been made to identify or locate such person (including a notice of the payment due mailed to the last known address of such Covered Person or other person as shown on the records of the Employer), such payment and all subsequent payments otherwise due to such Covered Person or other person shall be forfeited eighteen (18) months after the date such payment first became due.

3. Payment to Persons Other Than Participants

If the Plan Administrator shall find that any person to whom a benefit is payable under the Plan is unable to care for the person's affairs, is a minor

or has died, then any payment due to that person or that person's estate (unless a prior claim therefor has been made by a duly appointed legal representative) may be paid to the spouse, a child, a relative, an institution maintaining or having custody of such person or any other person that the Plan Administrator determines to be a proper recipient on behalf of such person otherwise entitled to payment. The Plan Administrator may, in the Plan Administrator's discretion, hold such payment until a legal representative is appointed. Any such payment shall be a complete discharge of the liabilities of the Plan.

4. Plan's Right to Recover Overpayments or Mistaken Payments

If a payment for a claim filed by or for an Employee, Retiree or Dependent of an Employee or Retiree is found to be more than the amount payable under the terms of the Plan or is found to have been made in error, then a refund of the excess or erroneous payment may be requested. If a requested refund is not paid or if none is requested, the Plan Administrator may take whatever action the Plan Administrator determines is necessary to recover the overpaid or mistakenly paid amount, including, but not limited to, reducing benefits payable for future claims filed by or for the Employee, Retiree or any Dependent of an Employee or Retiree to offset the overpaid or mistakenly paid amount or bringing a legal action against the Employee, Retiree or Dependent of an Employee or Retiree to collect the overpayment. If it is necessary for the Plan to institute legal proceedings to collect an overpayment and the Plan prevails, the Employee, Retiree or Dependent of an Employee or Retiree will be responsible for paying the reasonable attorney's fees and costs that the Plan incurs in connection with such action.

SECTION R. PLAN'S RIGHTS TO SUBROGATION AND REIMBURSEMENT

1. Generally

If this Plan pays out medical or disability benefits to or on behalf of a covered person in connection with an Injury or Illness for which a third party may be responsible, the Plan has the right to recover those benefits either directly from the third party or from the covered person. While these subrogation and reimbursement provisions are most often relevant in connection with automobile accidents, they also apply in any situation in which a covered person's Injury or Illness is caused by a third party. For example, these provisions apply if a covered person is injured by a faulty product, or by some defective condition of a third party's property.

2. Definitions

For purposes of these reimbursements and subrogation provisions, a "covered person" is a person to or on whose behalf this Plan pays out benefits. The term "covered person" also includes such individual's guardian, estate, heirs, or other representatives.

For purposes of these reimbursement and subrogation provisions, a "third party" is a person who caused the covered person's Injury or Illness and any other person or entity that has an obligation to pay compensation of any sort to the covered person as a result of that Injury or Illness. For example, both the insurer of the responsible third party and the insurer of the covered person are included in the meaning of "third party" to the extent such insurers are obliged to compensate the covered person as a result of the Injury or Illness. Thus to the extent the injured person's own insurer is obliged to compensate the injured person under the injured person's uninsured or underinsured motorist coverages, the injured person's own insurer will be a "third party."

3. Plan's Right to Reimbursement

If the Plan pays out any benefits of any sort to or on behalf of a covered person in connection with an Injury or Illness for which a third party may be responsible, such benefits are paid on the express condition that the covered person must reimburse the Plan from the proceeds of any settlement or recovery that the covered person receives from or through such a third party or parties. The Plan has the right to recover the amount of the benefits it paid out in connection with the Injury or Illness if the covered person recovers any amount from or through any third party or parties. The covered

person's spouse is also required to reimburse the Plan to the extent the spouse recovers damages in connection with the Injury or Illness to the covered person from any third party by reason of the injury to the covered person.

The description or characterization of any recovery from any third party does not affect the Plan's right to reimbursement. By accepting benefits from the Plan, the covered person and the covered person's spouse acknowledge the Plan's right to reimbursement and agree to make such reimbursement, and agree to hold any recovery received from a third party in trust for the Plan, to the extent of the amount of benefits the Plan paid out in connection with that Injury or Illness. The covered person and the covered person's spouse must reimburse the Plan in full from any recovery from any third party or parties for benefits the Plan paid in connection with the Injury or Illness before any other amounts are deducted from the recovery paid by the third party or parties.

The Plan Administrator, in the Plan Administrator's sole and absolute discretion, based on all of the circumstances, including the total amounts of the recovery and the costs and attorney's fees incurred by the covered person, may determine it is in the best interests of the Plan to reduce the Plan's claim for reimbursement.

4. Plan's Right to Subrogation

"Subrogation" means the substitution of one person in the place of another with respect to a claim, demand or right.

To the extent of the benefits it pays out, the Plan will be subrogated to all claims, demands, actions and rights of action the covered person may have against any third party or parties. This means that to the extent the covered person has a claim against anyone as a result of an Injury or Illness for which the Plan pays out benefits, the Plan has a right to pursue the covered person's claim. In effect, the Plan "stands in the place" of the covered person with respect to such claim or claims. For example, if the covered person is injured in an auto accident caused by another individual and the Plan pays out benefits for the treatment of the covered person's Injury, the Plan could, on its own, sue the individual who caused the accident or, if the covered person sued that individual, the Plan could join in the covered person's lawsuit.

The amount of the Plan's subrogation interest is equal to the amount the Plan paid out in connection with the Injury or Illness, plus the attorney's fees

and costs the Plan incurs in pursuing the claim against the third party or parties.

The Plan may assert the Plan's claim against any third party even if the covered person does not, or the Plan may join in any action the covered person brings against any third party or parties. The Plan does not waive any of the Plan's rights to reimbursement by not independently asserting its claim against any third party or by not joining in any action brought by the covered person against any third party.

By accepting benefits from this Plan in connection with any Injury or Illness for which a third party may be responsible, the covered person expressly acknowledges the Plan's rights to subrogation and agrees to do nothing to prejudice those rights and to cooperate fully with the Plan in asserting those rights.

5. Covered Person's Responsibilities

In order to receive benefits from the Plan in connection with an Injury or Illness for which a third party may be responsible to compensate the covered person, that covered person (and, if applicable, the covered person's spouse) must do all of the following:

a. Notify the Plan when the covered person suffers an Injury or Illness for which a third party may be required to compensate the covered person;

b. Provide the Plan with any and all documents and information regarding the Injury or Illness the Plan may request;

c. Execute an agreement setting forth the Plan's rights and the covered person's obligations and the obligations of the covered person's spouse under these subrogation and reimbursement provisions. If the covered person is represented by an attorney, that attorney must also sign the subrogation agreement;

d. Provide the Plan with notice if the covered person asserts a claim or claims against any third party and keep the Plan informed as to the status of such claim or claims;

e. Obtain the written consent of the Plan or its designee prior to settling any claim to which this Plan is subrogated;

f. Notify the Plan of any compensation the covered person or the covered person's spouse receives from any third party in connection with the Injury or Illness and immediately reimburse the Plan for the benefits the

Plan paid out from such compensation from the third party or parties upon the receipt of such compensation;

g. Cooperate fully with the Plan in its efforts to protect and exercise its rights to subrogation and reimbursement; and

h. Take no actions to compromise or impair the Plan's rights to reimbursement or subrogation.

If the covered person or the covered person's spouse fails to comply with these obligations, the Plan will not pay out benefits in connection with that Injury or Illness. If the covered person or the covered person's spouse fails to reimburse the Plan for the benefits the Plan paid out from any recovery they receive from the third party or parties as required, the Plan may withhold future benefits due the covered person and the covered person's covered Family members or may take any other such action necessary to enforce the Plan's right to reimbursement.

6. Rejection of "Make-Whole" Doctrine

This Plan specifically rejects the "make-whole" doctrine. The Plan's rights to reimbursement and subrogation do not depend on whether the covered person or the covered person's spouse recovers from third parties monies sufficient to fully compensate the covered person or the covered person's spouse, or both, for their losses.

7. Plan's Enforcement of These Provisions

In the event the covered person or the covered person's spouse fails to fulfill his or her obligations under these reimbursement and subrogation provisions, the Plan may take any action the Plan Administrator determines is necessary to enforce the Plan's rights under these provisions. The Plan may refuse to pay benefits in connection with the Injury or Illness if the covered person or the covered person's spouse fails to fulfill his or her obligation to provide information and documents or fails to execute the required reimbursement and subrogation agreement. If the Plan does pay benefits and the covered person or the covered person's spouse later fails to fulfill his or her duties, the Plan may withhold future benefits from the covered person and the covered person's family members, may bring an action against the covered person and the covered person's spouse, or may recoup amounts it paid out from the providers to whom it was paid or any other sources. Should the Plan bring legal action to enforce the Plan's rights under these reimbursement and subrogation provisions, and succeed in

whole or in part in such action, the covered person or the covered person's spouse shall pay the legal fees and costs the Plan incurs in that action.

8. Future Claims Relating to The Same Injury Or Illness

Once the covered person's claims against the third party or parties are resolved, the Plan will not pay out any additional benefits in connection with the Injury or Illness caused by the third party until the total claims that would otherwise be covered under the Plan exceed the total amount of compensation paid to or on behalf of the covered person and/or the covered person's spouse by the third party or parties. In such a situation only the excess portion of the otherwise covered claims will be treated as covered.

SECTION S. PLAN ADMINISTRATION, AMENDMENT AND TERMINATION

1. Plan Administration

The Board of Trustees of the Sheet Metal Workers Local Union 268 Welfare Plan shall have all discretionary authority and responsibility for the administration and interpretation of the Plan. For purposes of ERISA, the Board of Trustees shall be the "named fiduciary" with respect to matters for which the "named fiduciary" is responsible. To the maximum extent permitted by ERISA, every action and determination of the Board of Trustees shall be final and binding on all parties. The Board of Trustees intends that the most deferential standard of judicial review shall apply to their decisions.

In furtherance of, and not by way of limitation on, the responsibilities and authority conferred on the Board of Trustees herein, the Board of Trustees shall administer the Plan in accordance with its terms and provisions and shall have the following specific responsibilities and authorities:

a. To interpret, construe and apply the terms of the Plan, including any ambiguous terms;

b. To determine all questions concerning eligibility to participate and receive benefits under the Plan, questions concerning whether the expense of any given treatment or service is a covered expense, and any other question which may arise in the administration or operation of the Plan;

c. To employ such independent consulting actuary, certified public accountant, legal counsel, and other persons as may be required by ERISA or as they shall otherwise deem necessary or appropriate in connection with the administration and operation of the Plan; and

d. To take any other required action under the Plan.

2. Plan Amendment and Termination

The Board of Trustees of the Sheet Metal Workers Local Union 268 Welfare Plan shall have the sole authority and right at any time to adopt, amend or modify the Plan, retroactively or otherwise, or to terminate or partially terminate the Plan, subject to applicable law and collective bargaining agreement provisions. No such amendment or termination shall cause or permit the Plan to be used for any purpose other than the payment of Plan benefits or administrative expenses. Nor shall any such amendment or termination in any manner impair the right of a Covered Person who has

incurred covered expenses or is entitled to payment of benefits under the Plan at the time of the adoption of such amendment or termination, to receive such benefit provided for under the Plan prior to such amendment or termination.

3. Filing of Information

Each Plan Participant or other interested person shall file with the Plan Administrator such pertinent information concerning such person as the Plan Administrator may specify, including proof or continued proof of eligibility or dependency, and in such manner and form as the Plan Administrator may specify, and such person shall not have any right or be entitled to any benefit or further benefits hereunder unless such information is filed by such person or on such person's behalf.

4. Loss of Benefit

To determine if you are eligible for benefits, contact the Plan Administrator. You must continue to be a member of the class to which the Plan pertains. Failure to do so may result in partial or total loss of your benefits.

5. Participant's Rights Under ERISA

a. Receive Information About Your Plan And Benefits

As a Plan Participant in the Sheet Metal Workers Local 268 Welfare 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:

(1) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, if applicable, all documents governing the Plan, including insurance contracts and collective bargaining agreements, if any, 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, if any, and copies of the latest annual report (Form 5500 Series) and an 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. The Plan Administrator is required by law to furnish each Plan Participant with a copy of this summary annual report.

b. Continue Group Health Plan Coverage

Continue health care coverage for yourself, Spouse or Dependent Children if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan (including the section on the rules governing your COBRA continuation coverage rights).

c. Prudent Action By Plan Fiduciaries

In addition to creating rights to Plan Participants, ERISA imposes duties upon the individuals who are responsible for the operation of the employee benefit plan. The individuals 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 their beneficiaries. No one, including your employer, may fire you or otherwise discriminate against you in any way to prevent you from obtaining benefits under the Plan or from exercising your rights under ERISA.

d. Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive then 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 to pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in state or federal court.

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

If it should happen that a Plan fiduciary misuses the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if the court finds the claim or suit to be frivolous.

e. Assistance With Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or 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, DC 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.

SECTION T. HIPAA NOTICE OF PRIVACY AND SECURITY PRACTICES

The Plan must comply with the Health Insurance Portability and Accountability Act ("HIPAA").

This notice describes how medical information about you may be used and disclosed, explains how you can get access to this information, and informs you of your rights related to your health information. Please read it carefully. We are required by law to:

1. Maintain the privacy of your health information;

2. Give you this notice of our legal duties and privacy practices with respect to health information about you; and

3. Follow the terms of the notice that is currently in effect.

1. How We May Use and Disclose Medical Information About You:

We may use your protected health information (PHI), as described in each category below, for treatment purposes, for payment purposes, and for our health care operations. We provide for each of these categories an example of how your health information might be used.

a. Treatment

We may use or disclose your health information to facilitate your health care treatment. For example, we might disclose information to your health care provider to assist them in making a determination on a course of treatment for you.

b. Payment

We may use and disclose health information about you for purposes related to payment. For example, we may use your health information to obtain premiums or to determine our responsibility for coverage under the plan. As another example, we may use your health information to coordinate benefits with another health plan.

c. Health Care Operations

We may use and disclose health information about you in order to carry out the day-to-day health care operations of our health plan. For example, we may use health information in connection with:

- Legal services;

- Audit services;
- Business planning and development;
- Business management of the Plan;
- Contracting for reinsurance – For example, PHI may be disclosed to carriers of stop loss insurance to obtain premium quotes. However, consistent with the Genetic Information Nondiscrimination Act (GINA), the Plan is prohibited from disclosing genetic information for underwriting purposes.
- Reporting to Trustees – For example, the Plan may disclose information to the Board of Trustees of the Plan for appeals or other plan operations.

2. The Plan's Disclosure of PHI to the Trustees

In the course of business practices, the Plan may disclose information to Board of Trustees of the Plan, acting as Plan Sponsor, for reviewing and making determinations regarding an appeal or for monitoring benefit claims or analyzing benefit structure and claim experience including those that may or do involve stop-loss insurance. Generally, the Plan will disclose PHI to the Plan Sponsor only if necessary for Plan operations. With respect to PHI, the Plan Sponsor agrees to:

a. Not use or further disclose PHI other than as permitted or required by the plan documents or as required by law;

b. Ensure that any agents, including subcontractors, to whom it provides PHI received from Health Plan agree to the same restrictions and conditions that apply to Plan Sponsor with respect to such information;

c. Not use or disclose PHI for employment-related actions and decisions;

d. Not use or disclose PHI in connection with any other benefit or employee benefit plan of Plan Sponsor;

e. Report to Health Plan's Privacy or Security Office any PHI use or disclosure that it becomes aware of which is inconsistent with the uses or disclosures provided for;

f. Make PHI available to an individual based on HIPAA access requirements;

g. Make PHI available for amendment and incorporate any PHI amendments based on HIPAA amendment requirements;

h. Make available the information required to provide an accounting of disclosures;

i. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Health Plan available to the Secretary of the U.S. Department of Health and Human Services to determine the Health Plan's compliance with HIPAA;

j. Ensure that the adequate separation between the group health plan and the plan sponsor is established as required by HIPAA (45 CFR 164.504(f)(2)(iii)); and

k. If feasible, return or destroy all PHI received from the Health Plan that Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the specified disclosure purpose. If return or destruction is not feasible, Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction infeasible.

l. Implement administrative, physical and technical safeguards that reasonable and appropriately protect the confidentiality, integrity, and availability of the PHI that it creates, receives, maintains, or transmits on behalf of the Plan.

m. Ensure "adequate separation" supported by reasonable and appropriate security measures. "Adequate separation" means the Plan Sponsor will use PHI only for Plan administration activities and not for employment-related actions or for any purpose unrelated to Plan administration. Any employee or fiduciary of the Plan or Plan Sponsor who uses or discloses PHI in violation of the Plan's security or privacy policies and procedures shall be subject to the Plan's disciplinary procedure.

n. Ensure that any agent or subcontractor to whom it provides PHI agrees to implement reasonable and appropriate security measures to protect the information

o. Report to the Plan Security Officer any security incident of which it becomes aware.

3. Other Potential Uses and Disclosures

In addition to the general uses and disclosure of your information discussed above, there may be other special situations where it is necessary, and permissible, for us to use or disclose your health information. These situations are discussed below:

a. As Required by Law.

The Plan may use or disclose PHI to the extent that such use or disclosure is required by law and complies with and is limited to the relevant requirements of such law.

b. Public Health Activities.

For example, we may disclose information to a public health authority for the purpose of preventing or controlling disease.

c. Reporting Abuse, Neglect or Domestic Violence.

For example, circumstances may arise where we need to disclose to appropriate authorities suspected abuse or domestic violence.

d. Health Oversight Activities.

We may disclose health information to a health oversight agency for health oversight activities, including audits, health care fraud investigations, inspections, and other oversight activities authorized by law.

e. Judicial or Administrative Proceedings.

For example, we may disclose information pursuant to a court order, subpoena, or a discovery request related to a trial proceeding.

f. Law Enforcement Purposes.

For example, it may be necessary for us to disclose information to law enforcement officials regarding the identification or location of suspects, fugitives, or missing persons.

g. Medical Directors, Coroners, and Funeral Directors.

In the event of your death, we may disclose your health information to medical directors, coroners, or funeral directors. For example, disclosure may be necessary for determining a cause of death.

h. Organ and Tissue Donation.

We may disclose your information to organizations handling organ and tissue donation.

i. Disclosures to Avert a Serious Threat to Health or Safety.

For example, we may disclose information to appropriate authorities in order to protect the safety of an individual.

j. For Specialized Government Functions.

We may disclose health information pursuant to certain governmental functions. For example: military or veteran activities; or national security activities.

k. Workers' Compensation.

We may release information in accordance with applicable Workers' Compensation laws.

l. Disclosures to the Plan Sponsor.

The Plan may disclose health information to the Trustees of the Plan in order to carry out plan administration functions.

4. All Other Uses or Disclosures

We may not use or disclose your health information for any other purpose other than described above without your specific written authorization. You may revoke any such authorization in writing at any time. However, any revocation is limited to the extent that the Plan has already taken action in reliance upon your authorization.

5. Your Rights Regarding Health Information

Federal law provides you with several rights regarding your health information:

a. Right to Inspect and Copy Your Health Information.

You have the right to inspect and copy the health information that we maintain about you. If you request a copy of your information, we may charge a reasonable fee for the costs of copying, mailing or other supplies associated with your request. You must submit any request to inspect or copy your health information in writing. All such written requests should be forwarded to:

Sheet Metal Workers Local 268 Health and Welfare Fund
Attention: Privacy Officer
2701 North 89th Street
Caseyville, IL 62232

b. Right to Amend Your Health Information.

You have the right to request an amendment to your health information maintained by our Plan, for as long as the information is kept by our Plan. You may wish to request an amendment to your information if you feel that the information is inaccurate or incomplete. A request must state the reason you feel the amendment is necessary. You must make any request for amendment in writing. Your request should be submitted to the Privacy Officer at the address above.

c. Right to an Accounting of Disclosures.

You have the right to receive an accounting of certain disclosures of your health information made by the Plan. This accounting does not include disclosures made pursuant to treatment, payment, healthcare operations, or your individual authorization. You must submit a request for an accounting of disclosures in writing to the Privacy Officer at the address above.

Your request should state the time period for which you would like an accounting, which cannot go beyond the six-years prior to the date of your request. You are entitled to one free accounting within any 12-month period. We may charge you a reasonable fee for any other accounting made within this same 12-month period. We will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.

d. Right to Request Restrictions.

You have the right to request specific restrictions on our uses and disclosures of your health information. For example, you have the right to request that we not disclose any of your health information for treatment purposes. We do not have to agree to a requested restriction. Agreeing to a restriction is within our sole discretion.

e. Right to Request Confidential Communications.

You have the right to request that we communicate specific information to you in a certain manner or at a certain location, if you feel that the communication might otherwise place you in danger. For example, you may request that an explanation of benefits be sent to your work rather than to your home if you feel that this information may put you in danger if sent to your home. Any request for a confidential communication must be made in writing and be accompanied by a statement that the

confidential communication is necessary to avoid your personal endangerment. All requests should be submitted to the Privacy Officer at the address above.

f. Right to a Paper Copy of This Notice.

You have the right to receive a paper copy of this notice at any time. To request a paper copy of this notice, please contact the Privacy Officer at the address above.

6. Revisions to This Notice

We reserve the right to change the terms of this notice. Any changes to this notice will be effective for health information that we maintain about you. Should we revise this notice, we will promptly provide you with a new Notice by mailing you a written copy of the new notice.

7. Complaints

If you believe your privacy rights have been violated, you have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. Your privacy rights will not be affected by filing a complaint. Further, you will not be retaliated against in any manner for filing a complaint.

To file a complaint with the Plan, contact:

Sheet Metal Workers Local 268 Health and Welfare Fund
Attention: Privacy Officer
2701 North 89th Street
Caseyville, Illinois 62232

8. Security Rule

The Plan is required to comply with the HIPAA Security Rule. The Security Rule addresses the security of electronically maintained protected health information. While security measures have always been in place, the Security Rule requires that certain safeguards be documented in Plan documents. Accordingly, the Plan has implemented the following measures:

a. Administrative, physical, and technical safeguards have been implemented that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information it creates, receives, maintains, or transmits;

b. There is adequate separation (or firewall) between the information that is received from the Plan and other employment information and

decisions, and this separation is supported by reasonable and appropriate security measures; and

c. Any agent, including any subcontractor, to whom the Plan provides electronic protected health information agrees to implement reasonable and appropriate security measures to protect the information.

9. Breach Notification

The Plan is subject to the HITECH breach notification rules. In the unlikely event that your protected health information is breached, as that term is defined under HITECH, we will provide you with written notice of the breach. The notice will be sent without unreasonable delay and in no case later than 60 calendar days after discovery of a breach. The notice will be written in plain language and will contain the following information:

a. A brief description of what happened, the date of the breach if known, and the date of discovery;

b. The type of PHI involved in the breach;

c. Any precautionary steps you should take;

d. What we are doing to mitigate the breach and prevent future breaches; and

e. How you may contact us to discuss the breach.

We will also report the breach to the U.S. Department of Health and Human Services.

The Plan is required by law to:

- Maintain the privacy of your health information;
- Give you this notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the notice that is currently in effect.

SECTION U. GENERAL PLAN INFORMATION

1. Plan Name

Sheet Metal Workers Local Union 268 Welfare Plan

2. Plan Number

501

3. Employer Identification Number

37-0842910

4. Plan Effective Date as Amended and Restated

July 1, 2022

5. Plan Year

The Plan's financial records are maintained on a fiscal year basis that runs from July 1 through June 30. Benefit records are maintained on a calendar year basis, including deductibles and out-of-pocket maximums where applicable.

6. Plan Sponsor and Plan Administrator

Board of Trustees of the Sheet Metal Workers
Local Union 268 Welfare Plan
2701 North 89th Street
Caseyville, Illinois 62232
618-397-1443

As of July 1, 2022, the Trustees are:

Union Trustees:

Jeff Bauer
2701 North 89th Street
Caseyville, Illinois 62232

John LePere
2701 North 89th Street
Caseyville, Illinois 62232

Jonathan Mentz
7554 Brickyard Hill Road
Worden, Illinois 62097

Employer Trustees:

Phil Halliday
JEN Mechanical, Inc.
2813 West Delmar Avenue
Godfrey, Illinois 62035

Brian Langhauser
Langhauser Sheet Metal Company
120 Matter Drive
Highland, Illinois 62249

Brad McPherson
2208 Briarcliff Drive
Alton, Illinois 62202

7. Type of Plan

The Sheet Metal Workers Local Union 268 Welfare Plan is a multiemployer welfare plan providing medical, prescription drug, and short-term disability benefits. All benefits are paid through a trust (hereinafter called the "Trust") that has been established for the exclusive benefit of (a) Employees and Retirees of participating Employers and the eligible Dependents of such Employees and Retirees, and (b) Employees and Retirees of Sheet Metal Workers Local 268 and of the fringe benefit funds administered by Sheet Metal Workers Local 268, and the eligible Dependents of such Employees and Retirees.

8. Type of Administration

The Board of Trustees of the Sheet Metal Workers Local Union 268 Welfare Plan administers the overall operation of the Plan.

The Board of Trustees has entered into an agreement with a Preferred Provider Organization, which permits Covered Persons to have access to the Preferred Provider Organization's network of healthcare providers. A current list of doctors, hospitals and other healthcare providers who are members of the Preferred Provider Organization's network can be obtained at the Preferred Provider Organization's website. The name, address and website for the Preferred Provider Organization are:

Meritain Health
P.O. Box 853921
Richardson, Texas 75085-3921
800-343-3140
www.aetna.com/docfind/custom/mymeritain

The Board of Trustees have also entered into a pharmacy benefits management agreement through which Covered Persons have access to a network of pharmacies. The pharmacy benefits manager (PBM) will also process claims for reimbursement for drugs obtained outside the network. The name, address and website for the PBM are:

Citizens Rx
1144 Lake Street
Oak Park, Illinois 60301
1-877-532-7912
www.citizensrx.com

In addition, the Board of Trustees have entered into an agreement with a claims processor to make initial claim determinations and otherwise assist

the Board of Trustees in administering the Plan claims and appeal procedures. The claims processor also performs the Medical Management Program services. The name, address and website of the claim processor are:

Meritain Health
P.O. Box 853921
Richardson, Texas 75085-3921
1-800-776-2452
www.Meritain.com

Benefits for Retirees who are eligible for Medicare will be provided through a separate insured policy through:

Labor First
3000 Midatlantic Drive, Ste. 101
Mount Laurel, New Jersey 08054
1-618-248-8307

9. Collective Bargaining Agreements

This Plan is maintained pursuant to one or more collective bargaining agreements. A copy of any applicable collective bargaining agreement, as well as a list of participating Employers, may be obtained upon request and free of charge, by contacting the Plan Administrator. A Covered Person may also examine any applicable collective bargaining agreement and list of participating Employers, upon request and free of charge, at the Plan Administrator's office during normal business hours.

10. Funding of the Plan

All costs of the Plan, including Plan benefits, Plan administrative expenses, and the retention of experts and advisors, are paid through the Trust. The Trust funds are derived solely from (a) contributions made by a participating Employer pursuant to a collective bargaining agreement, or by a participating Employer who is signatory to a written agreement between the participating Employer and Plan Sponsor; (b) contributions made by Plan Participants; and (c) from earnings on such contributions.

The funds are held in Trust and are governed by the Board of Trustees of the Sheet Metal Workers Local Union 268 Welfare Plan.

The level of any Plan Participant contribution is based on the amount of monies necessary to provide the coverage required by the Plan and is set out in the applicable collective bargaining agreement with an Employer or other

agreement between and Employer not subject to a collective bargaining agreement and the Plan Sponsor.

11. Agent for Service of Legal Process

The name and address of the person designated as the agent for the purpose of accepting service of legal process on behalf of the Plan is:

Jeff Bauer
Sheet Metal Workers Local Union 268 Welfare Plan
2701 North 89th Street
Caseyville, Illinois 62232

In addition, legal process can be accomplished by serving any current Plan Trustee.

IN WITNESS WHEREOF, the Sheet Metal Workers Local 268 Welfare Plan Document and Summary Plan Description is thus restated effective July 1, 2022.

UNION TRUSTEES

Jeff Bauer	10/17/2022 Date	Phil Halliday	10/17/2022 Date
John LePere	10-17-22 Date	Brian Langhauser	10/17/2022 Date
Jonathan Mentz	Date	Brad McPherson	10/17/22 Date