Sheet Metal Workers' Local 73 Welfare Fund
Plan for Retired Members

Summary Plan Description/Plan Document

Amended, Restated, and Effective July 1, 2023

July 1, 2023

SHEET METAL WORKERS' LOCAL 73 WELFARE FUND
PLAN FOR RETIRED MEMBERS

4530 Roosevelt Road
Hillside, Illinois 60162
Telephone: 1-708-449-7373
Facsimile: 1-708-449-7333
Facsimile: 1-708-449-7606
Website: www.sm73funds.org

BOARD OF TRUSTEES

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CONSULTANTS TO THE WELFARE FUND

The Segal Group, Inc.

This booklet serves as both the Summary Plan Description (SPD) and Plan Document for the Sheet Metal Workers' Local 73 Welfare Fund Plan for Retired Members. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.

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To All Eligible Participants:

The Board of Trustees is pleased to present you with this booklet that describes the benefits provided to Retired Employees and their Dependents under the Sheet Metal Workers' Local 73 Welfare Fund as of July 1, 2023, and supersedes all previous Summary Plan Description (SPD) booklets, Plan Documents and related materials. A separate booklet describes the benefits for Plan A members and their Eligible Dependents, Plan C (Bargained) members and their Eligible Dependents, Plan C (Non-Bargained) for Contractor members and their Eligible Dependents, and Plan C for Staff and their Eligible Dependents..

This booklet provides information on how you and your Eligible Dependents may qualify for benefits and just what benefits (medical, dental, vision, prescription drug, and death, etc.) the Fund covers. You can also visit the Fund's Web site at www.sm73funds.org for a summary of the provisions of this booklet.

It is important for the orderly and proper processing of your claims to have your current address on file with the Fund Office. Therefore, if you change your address, please contact the Fund Office immediately.

You may change your designated Beneficiary only by completing a new Universal Beneficiary Designation Form and filing it with the Fund Office. If you want to change your Beneficiary or if you have not yet filed a Universal Beneficiary Designation Form, please contact the Fund Office.

It is the goal of the Trustees to provide Retirees and their Dependents with the best health and welfare benefits within the financial limitations of the Fund. We will continue to strive toward this goal.

Best wishes for your good health.

Sincerely,

BOARD OF TRUSTEES

The Board of Trustees reserves the right, whenever in their judgment, conditions so warrant, to:

(1) Alter, amend, modify or discontinue the level of benefits, the rate of self-payments, and

(2) Discontinue the Plan and discontinue the further payments of the Plan at any time.

However, as long as the Plan is in existence, the Plan will be administered for the exclusive benefit of covered Retirees and their Dependents or Beneficiaries.

SHEET METAL WORKERS' LOCAL 73 WELFARE FUND PLAN FOR RETIRED MEMBERS

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Important Contact Information

The chart that follows shows the contact information for the various organizations that provide services under the Sheet Metal Workers' Local 73 Welfare Fund for Retired Members.

If You Have a Question or Need Information About	Contact	Phone Numbers and Websites
Eligibility; Benefits, or Medical Claims	Fund Office	1-708-449-7373 www.sm73funds.org
Pre-admission authorization for Hospital Admissions/Inpatient Medical Services	Valenz Care	1-800-367-1934 www.valenzhealth.com
Pre-certification for a Mental or Nervous Disorder Service or Substance Abuse	Valenz Care	1-800-367-1934 www.valenzhealth.com
Whether a Provider is part of the BCBS PPO Network	Blue Cross Blue Shield of Illinois	1-800-810-BLUE to Verify if a Provider is PPO Contracted www.bcbsil.com
Dental claims or a list of Network Providers	Delta Dental of Illinois	1-800-323-1743 www.deltadentalil.com
Vision claims	EyeMed	1-866-723-0514 www.eyemedvisioncare.com
Retail or Mail Order Prescription Drug Benefits	Express Scripts, Inc. ("ESI")	1-866-544-2916 www.express-scripts.com
Death, Accidental Death and Dismemberment	Fund Office	1-708-449-7373 www.sm73funds.org
Plan Legal Issues	Fund Office	1-708-449-7373 www.sm73funds.org

Important Benefit Information

You should keep these points in mind when using the benefits provided by the Plan:

1. Pre-admission authorization is recommended for elective or non-emergency hospitalization or elective Inpatient surgery. You should Valenz Care at least one (1) business day before you go into the Hospital, or within two (2) business days of the date of an emergency admission. See the back of your medical ID card for instructions. You are encouraged, but not required, to contact Valenz Care for maternity admissions. Pre-admission authorization is not a guarantee that all services and charges will be paid for by the Fund. Your benefits are still subject to all terms and conditions of the Plan.

2. If you and your spouse become divorced or legally separated, you or your spouse must notify the Fund Office. Your spouse is not eligible for coverage under the Plan as your Dependent as of the date of your divorce or legal separation. Your spouse may be eligible for continuing coverage for thirty-six (36) months after the divorce or legal separation under COBRA. However, to be eligible for COBRA coverage, you or your spouse must notify the Fund Office within sixty (60) days of the divorce or legal separation. Please see pages 24-27 or contact the Fund Office if you have any questions about continuing coverage under COBRA.

3. If your Child loses Dependent status under the Plan because your Child no longer meets the Plan's definition of Dependent, you, your spouse, or your Dependent Child must notify the Fund Office within sixty (60) days of the loss of status in order to be eligible for COBRA continuation coverage. See pages 24-27 or contact the Fund Office if you have any questions about continuing coverage under COBRA.

4. Certain routine diagnostic tests are covered by the Preventive Services Benefit or Wellness Benefit, as applicable. Other tests may be covered if you receive pre-approval by Valenz Care. See page 44 for more details about the tests that are covered under the Preventive Services Benefit or page 54 for more details about the tests that are covered under the Wellness Benefit.

5. This Plan coordinates its healthcare benefits (but not prescription drug benefits) with the benefits of any other Plan under which you and your Dependents are covered. If you and/or your Dependents are covered under another plan, you must report all other coverage directly to the Fund Office.

6. Call the Fund Office at 1-708-449-7373 or Blue Cross Blue Shield at 1-800-810-BLUE, or visit the Blue Cross Blue Shield of Illinois website at www.bcbsil.com to find out if a particular provider is a Plan/PPO contracted provider , before you use their services.

7. The fact that your Physician may prescribe, order, recommend or approve a particular service or supply does not make it Medically Necessary or make the expense a covered charge under the Plan. See page 33 for more detailed information about covered medical expenses.

8. Eligibility and benefit coverage are limited to and controlled by the terms of this written Plan Document. Fund Office employees, employers, union representatives, individual Trustees and individuals or entities other than the Board of Trustees acting in accordance with the Trust Agreement are not authorized or empowered to make representations, certify or guarantee coverage or interpret or change the terms of the Plan. You cannot rely upon their statements or actions to establish eligibility or benefit coverage. The Plan Document is the only instrument on which you can rely. If you would like to confirm eligibility or coverage you must file an official claim for benefits pursuant to the Plan's claim filing procedures set forth on page 76.

9. **Important:** If you believe you are entitled to a benefit that you have not received or if you disagree with any determination made by the Plan Administrator or Fund Administrator, as applicable, regarding your benefit (such as the amount of your benefit or how it is calculated), you may submit a claim for benefits under the Plan. However, the time period for submitting a claim for benefits is limited. If you fail to make a timely claim for benefits or you fail to timely appeal a claim, you may lose your right to those benefits. For important information regarding the process for submitting a claim for benefits and the deadlines for submitting such a claim, see the Plan's claim filing procedures set forth on page 76.

Schedule of Benefits

One of the following schedules is your *Schedule of Benefits*, depending on whether you are eligible for Medicare. You will find details about the benefits listed in these Schedules in the sections that follow.

Schedule of Benefits for Non-Medicare Eligible Retirees	
Benefit	**Amount**
Death Benefit (Employee Only; Taxable)	$15,000
Accidental Death and Dismemberment Benefit (Retiree Only)[1]	
For Your Death	$15,000
For Two Dismemberments	$15,000
For One Dismemberment	$7,500
Medical Benefit (Retiree and Dependents)	
Deductible: Individual/Family	$350/Maximum of 3 individual deductibles per family each calendar year
Coinsurance (% the Fund Pays for Most Covered Services, Unless Otherwise Specified) PPO Provider Non-PPO Provider	 80% 70% of the Reasonable and Customary Charge
Out-of-Pocket Maximum PPO Provider Non-PPO Provider	$2,000 per person each calendar year Not applicable[2]
Preventive Services (e.g., routine well child, OB/GYN visits, physicals, autism screening for Dependent Children, immunizations) PPO Provider Non-PPO Provider	 No charge; deductible does not apply 70% of the Reasonable and Customary Charge
Hospital and Ambulatory Surgical Facilities PPO Facilities Non-PPO Facilities Subject to Pre-Admission Authorization	80% 70% of the Reasonable and Customary Charge
Emergency Room Services PPO Facilities Non-PPO Facilities Subject to Pre-Admission Authorization[3]	 80% 80% of the Reasonable and Customary Charge (70% if non-emergency)
Benefit	**Amount**

[1] If you were covered under the Active Plan immediately prior to being covered under this Plan, your eligibility for the Plan's Death Benefit and Dismemberment and Accidental Death Benefit will continue for six (6) consecutive months after the effective date of your retirement.

[2] The Out-of-Pocket Maximum is also applicable to In-Network both Inpatient and Outpatient services for Mental Health and Substance Abuse. The Out-of-Pocket Maximum is not applicable for covered expenses received at non-PPO Hospitals or non-PPO Ambulatory Surgical Facilities, for services received from a Non-PPO Physician, treatment of infertility, or for non-covered expenses.

[3] See the Pre-Admission Authorization Section on page 32 for information about obtaining prior approval through Valenz Care before elective hospitalization, elective Inpatient surgery, dialysis facility, and skilled nursing facility, and the requirements for notifying Valenz Care of any emergency admission within certain timeframes.

Benefit	Amount
Physician's Services PPO Physicians Non-PPO Physicians	 85% 70% of the Reasonable and Customary Charge
Chiropractic Services PPO Providers Non-PPO Providers Calendar Year Maximum per Person	 85% 70% of the Reasonable and Customary Charge Up to 20 visits annually
Outpatient Physical therapy – Maximum 30 visits per year, subject to utilization review after the 30th visit Occupational therapy – Maximum 30 visits per year, subject to utilization review after the 30th visit	PPO Providers 85% PPO Facility 80% Non-PPO 70% of the Reasonable and Customary Charge PPO Providers 85% PPO Facility 80% Non-PPO 70% of the Reasonable and Customary Charge
Out-Patient Cardiac Rehabilitation Pulmonary Rehabilitation	36 Visits, Per Occurrence 36 Visits, Per Occurrence
Mental Health Treatment Inpatient PPO Facility Non-PPO Facility Outpatient PPO Physician Non-PPO Physician	 80% 70% of the Reasonable and Customary Charge 85% 70% of the Reasonable and Customary Charge
Substance Abuse Treatment Inpatient PPO Facility Non-PPO Facility Outpatient PPO Physician Non-PPO Physician	 80% 70% of the Reasonable and Customary Charge 85% 70% of the Reasonable and Customary Charge
Infertility Treatment Benefits Coinsurance Diagnosis of Infertility Treatment of Infertility	 50% of covered expenses No Maximum $20,000 (Combined Lifetime Maximum for You and Your Spouse)
Organ and Tissue Transplants	Treated the same as other medical expenses. (However, no deductible or coinsurance is applied if you use a Blue Cross Blue Shield Centers of Excellence Facility.)
Hospice Care Benefits Coinsurance Bereavement Counseling Maximum Lifetime Benefit	No charge; deductible does not apply Limited to 6 visits Up to 16 days for inpatient services; 80 days for outpatient services
Wigs or other cranial prostheses	80% up to $500 per person per calendar year
Cochlear Implants	Covered at 80% coinsurance in-network for Dependent children age one through 26 (out-of-network excluded) with no lifetime limit. Covered at 80% coinsurance in-network for members and spouses age 19 and older (out-of-network excluded) with a $30,000 lifetime limit.

Benefit	Amount	
ESI Prescription Drug Program	**Retail Program**	**Mail Order Program**
You should use the Prescription Drug Program in the following manner:	For immediate or short- term medications	For maintenance or long-term medications
You Pay		
Generic Drug (Per Prescription)	30%	30%
Brand Name Drug –Generic Available (Per Prescription)	35%	35%
Brand Name Drug – No Generic Available (Per Prescription)	30%	30%
Maximum Supply	34 days	90 days
Refill Limit	As prescribed	As prescribed
Calendar Year Deductible per Person	$50	
Calendar Year Out-of-Pocket Maximum	$2,000 Individual / $4,000 Family	
Reimbursement of Non-Network Pharmacy Expenses is explained on page 66.		
Contraceptives covered as a preventive service for women at 100% in-network without cost-sharing.		
Dental Benefits	***Amount***	
Calendar Year Deductible	$50 per person	
Type of Services		
Preventive Services	80%	
Basic Services	60%	
Major Services	40%	
Dental Anesthesia Services	40%	
Calendar Year Maximum Dental Benefits	$1,500 per person (No Maximum for children up to age 19 for pediatric preventive care and screenings)	
Optical (Vision) Benefits	***Amount***	
Lenses, Frames and Eye Examinations	Up to $425 per person (for PPO services) during a consecutive two-year period. (No Maximum for children up to age 19 for pediatric preventive care and screenings.) The EyeMed program provides additional benefits. First pair eye glasses covered under medical after cataract surgery.	
Hearing Aid Benefit	***Amount***	
Hearing Aid	$1,250 maximum per device	
Hearing Exam	Up to $150 per exam once per calendar year for Members and each Dependent	

Schedule of Benefits for Medicare Eligible Retirees		
Benefit	**Amount**	
Death Benefit (Retiree Only)[1]	$15,000	
Accidental Death and Dismemberment Benefit (Retiree Only)[1]		
For Your Death	$15,000	
For Two Dismemberments	$15,000	
For One Dismemberment	$7,500	
Wellness Expense Benefit (Retiree and Spouse Only)		
Physical Examination, Smoking Cessation Programs and Certain Tests and Laboratory Work	Unlimited. Deductible and coinsurance do not apply.	
Hospice Care Benefits		
Hospice Care Benefits Coinsurance Bereavement Counseling Maximum Benefit	No deductible or copayment Is required 100% paid by Fund Limited to 6 visits; Maximum of $50 per visit $10,000 per person	
ESI Prescription Drug Program	***Retail Program***	***Mail Order Program***
You should use the Prescription Drug Program in the following manner:	For immediate or short-term medications	For maintenance or long-term medications
You Pay		
Generic Drug (Per Prescription)	30%	30%
Brand Name Drug – Generic Available (Per Prescription)	35%	35%
Brand Name Drug – No Generic Available (Per Prescription)	30%	30%
Maximum Supply	34 days	90 days
Refill Limit	As prescribed	As prescribed
Calendar Year Deductible per Person	$50	
Calendar Year Out-of-Pocket Maximum	$2,000 Individual / $4,000 Family	
Reimbursement of Non-Network Pharmacy Expenses is explained on page 66.		
Dental Benefits	***Amount***	
Calendar Year Deductible	$50 per person	
Type of Services		
Preventive Services	80%	
Basic Services	60%	
Major Services	40%	
Dental Anesthesia Services	40%	
Calendar Year Maximum Dental Benefits	$1,500 per person (No Maximum for children up to age 19 for pediatric preventive care and screenings)	
Optical (Vision) Benefits	***Amount***	
Lenses, Frames and Eye Examinations	Up to $425 per person (for PPO services) during a consecutive two-year period. (No Maximum for children up to age 19 for pediatric preventive care and screenings.) The EyeMed program provides additional benefits. First pair eye glasses covered under medical after cataract surgery.	
Hearing Aid Benefit	***Amount***	

[1] If you are covered under the Active Plan on the date you retire, your coverage under the Plan's Death Benefit and Dismemberment and Accidental Death Benefit will continue for six (6) consecutive months after the effective date of your retirement.

Hearing Aid	$1,250 maximum per device
Hearing Exam	Up to $150 per exam once per calendar year for Members and each Dependent

Non-Medicare Eligible Retirees' Eligibility for Benefits

Eligibility Requirements for Non-Medicare Eligible Retirees

If you have not yet reached age 65 and are not yet eligible to enroll in Medicare, you may be eligible for benefits from this Plan. To be eligible, you must be receiving a pension from the Sheet Metal Workers' Local No. 73 Pension Fund (referred to as the Pension Fund or Pension Plan), and:

- You must be receiving a pension from the Pension Fund that is based on a minimum of ten (10) pension credits, but if the pension you are receiving from the Pension Fund is based on less than twenty-five (25) pension credits, you must have been credited with a minimum of three (3) pension credits within the period consisting of the Pension Plan year in which you retired and the six consecutive Pension Plan years immediately preceding the Plan Year during which you retired.
- If you have retired from a municipal or other governmental employer following a period of service that was covered under a collective bargaining agreement between such employer and the Union and are receiving a pension from the Pension Fund based on a minimum of twenty (20) but less than twenty-five (25) pension credits, you are eligible for coverage under this Plan if you are not eligible for coverage under a retiree health plan that your former municipal or governmental employer sponsors, contributes to or previously contributed to. For purposes of this paragraph, retiree health coverage means either self-insured or fully-insured health plan coverage, including an arrangement under which the retiree has the opportunity to select one or more self-insured or fully-insured health plan coverage options that are partially or fully subsidized by the retiree health plan that the municipal or governmental employer sponsors, contributes to, or previously contributed to. For the avoidance of doubt, retiree health coverage does not include a health reimbursement arrangement or health savings account arrangement that is not linked to either: (a) a self-insured or fully-insured health plan or (b) an arrangement under which the retiree has the opportunity to select one or more self-insured or fully-insured health coverage options; retiree health coverage shall, however, include a health reimbursement arrangement or health savings account arrangement that is linked to either: (a) a self or fully-insured health plan or (b) an arrangement under which the retiree has the opportunity to select one or more self-insured or fully-insured health coverage options that are subsidized in part or in full by the health reimbursement arrangement or health savings account. For the avoidance of doubt, if you have retired with twenty-five (25) or more pension credits from the Pension Fund, your eligibility for coverage under this Plan is not determined based on this bullet point paragraph but is determined under the other bullet point paragraphs of this section.
- If you served as a full-time officer or business agent of the Union, you will receive credit for the years of service to the Union as if you were receiving Pension Credits for the sole purpose of determining eligibility for coverage under this Plan at the time of retirement. Service as a full-time officer or business agent of the Union will not affect eligibility for welfare coverage upon retirement since contributions are made to the Welfare Fund by the Union for such service.
- For purposes of determining eligibility for benefits from this Plan, pension credits mean only those pension credits directly awarded by the Pension Fund and do not include pension credits awarded by another pension fund that are taken into consideration in regard to a Reciprocal Pension.

When you retire, you have the choice of electing coverage in the Retiree Plan or electing COBRA continuation coverage. If you choose COBRA continuation coverage, you waive coverage under this Retiree Plan. If you choose coverage under this Retiree Plan, you waive COBRA continuation coverage. This means that if you elect either COBRA continuation coverage or coverage under the Retiree Plan, you may not at a later date choose the other type of coverage.

As a Retiree, you are not eligible for Weekly Accident and Sickness Benefits. Those benefits end on the last day of your coverage under the Sheet Metal Workers' Local 73 Welfare Plan A for Active Members.

For the administrative convenience of the Plan, if you elect Retiree coverage and pay the required self-payment, you will continue to receive the benefits provided by the Sheet Metal Workers' Local 73 Welfare Plan A for Active Members until the end of the calendar year in which you retire. On and after the January 1 that follows your retirement date, you will receive the benefits provided by this Plan.

Continuation of Eligibility for Non-Medicare Eligible Retirees

Once you are eligible for Retiree Benefits, you must contribute toward the cost of this Plan for yourself and your eligible Dependents in order to continue your coverage.

Your contribution for Retiree Plan coverage may be deducted from your Pension each month.

Eligibility for Dependents of Non-Medicare Eligible Retirees

If you are a Non-Medicare Eligible Retiree, your Dependents become eligible for Benefits on the same date you become eligible, or, if later, on the date you acquire an eligible Dependent. Eligible Dependents are defined on pages 12 and 13.

These benefits are subject to Coordination of Benefits rules explained on page 97.

Deferring Coverage for a Spouse or Surviving Spouse of a Non-Medicare Eligible Retiree

At the time you retire, and provided your spouse produces evidence that your spouse is covered by another health benefit plan, you may elect that no self-contributions be paid for coverage of your spouse under this Plan, thereby excluding your spouse from coverage. There will be no coordination of benefits for such excluded spouse.

This election to defer your spouse's coverage is limited to your spouse at the time of your retirement only, or your surviving spouse, and will not cover any other future spouse. The election will not cover any spouse who marries you after your retirement. If your spouse loses other medical coverage during your retirement, you may elect to have your spouse added to coverage under this Plan within ninety (90) days of your spouse's loss of coverage. You may exercise this election only one time.

If your spouse or surviving spouse is, or becomes, eligible for this Plan and has health coverage under another plan through employment, your spouse or surviving spouse will be given a one-time opportunity to defer coverage under this Plan until your spouse or surviving spouse is no longer covered by your spouse's or surviving spouse's employer health plan.

To defer Plan coverage, you, your eligible spouse or surviving eligible spouse must meet the following requirements:

- Your eligible spouse or surviving eligible spouse must be eligible for coverage under this Plan,
- Your eligible spouse or surviving eligible spouse who becomes eligible for coverage under this Plan after September 1, 1995, must file a written election with the Fund Office,
- Your eligible spouse or surviving eligible spouse must provide proof of other insurance with the election, and

- If your eligible spouse or surviving eligible spouse does not file an election, your spouse will not be permitted to defer coverage.

To resume coverage, your eligible spouse or surviving eligible spouse must meet the following requirements:

- Your eligible spouse or surviving eligible spouse must have made a valid election to defer coverage as stated on page 10,
- Your eligible spouse or surviving eligible spouse must have been continuously covered by the health plan of his or her employer since the date that your spouse opted out of this Plan, and provide proof of that coverage,
- Your eligible spouse or surviving eligible spouse must apply to resume coverage with the Fund Office in writing, on or before the ninetieth (90th) day after termination of coverage under the health plan of your spouse's employer. If your spouse does not enroll within this period, your spouse will not be allowed to enroll at a future date, and
- Your eligible spouse or your surviving eligible spouse must make the contributions and payment required by the Sheet Metal Workers' Local 73 Welfare Fund Plan for Retired Members to maintain coverage.

Termination of Eligibility for Non-Medicare Eligible Retirees and Eligible Dependents

If you or your eligible Dependent fails to pay the required self-payments, coverage for you and your Dependents will terminate at the beginning of the month for which the required contribution was not paid.

When you or your Dependents become eligible to enroll in Medicare for any reason, coverage for you and your eligible Dependents will end under this Plan (regardless of whether you and your Dependents actually enroll in Medicare) unless you and your Medicare eligible Dependents enroll in the SMW+ Plan described on page 15.

Your surviving eligible spouse or eligible Dependents will remain covered by this Plan as long as they continue to meet the eligibility requirements.

If you become eligible for Medicare and you fail to enroll in the SMW+ Plan, your coverage and coverage for your eligible spouse will end under this Plan and will not be reinstated.

Your Dependents' Eligibility

Your Eligible Dependents become Participants in the Fund on the later of:

- The day you begin participation; or
- The date you enroll them with the Fund Office.

Your newborn Child, adopted Child, or Child placed with you for adoption will generally become covered as a Dependent under the Fund on the date the Child is born, adopted, or placed for adoption.

Example: Your Dependents' Eligibility

John becomes eligible for coverage under this Plan on September 1, 2023. John's spouse and his Dependent Children become eligible on the same date.

Eligible Dependents are defined as follows:

In general, your Dependents include your legal spouse and your Dependent Children.

- Your legal spouse;
- Your Dependent Children up to age 26; and
- Your Dependent Children of any age if mentally or physically disabled, as long as the mental or physical handicap began before the Child reached the end of the month that he or she turned age 26.

Dependent Children include married or unmarried dependents, regardless of student status, who are the member's natural children, adopted children, or children placed for adoption with the member, stepchildren foster children placed with the member by an authorized agency or by court order, judgment or decree and any other children for whom the member may have legal guardianship by court order, judgment or decree.

To enroll your newborn or newly acquired Child, you must provide the Fund Office with a copy of the birth certificate or adoption papers. Dependent status may continue until the end of the month of each Child's 26th birthday.

You must contact the Fund Office within thirty-one (31) days before Plan benefits might otherwise terminate (on the 1st of the month following the end of the month that he or she turns age 26) to apply for continued coverage for your disabled or handicapped Dependent Child.

If your Dependent Child is mentally or physically disabled or handicapped and is chiefly dependent on you, Plan benefits will continue as long as your Dependent is disabled or handicapped. To be eligible, your Child must be unable to engage in the normal activities of a person of like gender and age in good health due to disability or handicap. **You must contact the Fund Office within thirty-one (31) days before Plan benefits might otherwise terminate (on the 1st of the month following the end of the month that he or she turns age 26) to apply for continued coverage for your disabled or handicapped Dependent Child, and provide proof that your Dependent Child's disability will continue past the end of the month of his or her 26th birthday. For this purpose, you should submit the following documents for review: (1) Proof of approval by the Social Security Administration; (2) Copy of Child's Medicare card (if applicable); and (3) Letter from at least two (2) physicians which includes the disabled or handicapped Dependent Child's complete diagnosis and a description of mental and physical limitations. If you do not provide proof of your Dependent Child's continuing disability, his or her welfare coverage under the Plan will terminate as of the 1st of the month following the end of the month of his/her 26th birthday.**

An unmarried disabled Child who has reached age 26, but does not reside with you, will be a Dependent Child under the Plan if:

- The Child's parents are divorced or legally separated under a decree of divorce or separate maintenance, are separated under a written separation agreement, or live apart at all times during the last six (6) months of the calendar year;
- The Child's parents provide over one half of the Child's support during the calendar year; and
- The Child is in the custody of one or both of his or her parents for more than one half of the calendar year and is not the qualifying child of any other person during the calendar year.

The Plan will provide benefits for your Dependent Child who is named as an alternate recipient in a Qualified Medical Child Support Order (QMCSO).

Your Dependents' benefits are subject to the rules outlined in the *Coordination of Benefits* Section on page 97.

Qualified Medical Child Support Order (QMCSO)

A QMCSO is a court order that requires you to provide medical coverage for your Children (called alternate recipients) in situations involving a divorce, legal separation or a paternity determination.

This Plan provides benefits according to the requirements of the QMCSO. The Fund Administrator will notify you and any alternate recipient when a QMCSO is received. If the QMCSO is a valid order, the Plan will cover the named Dependent as an alternative recipient even though the Dependent might not otherwise be eligible for coverage.

Special Enrollment

This Plan complies with the federal law regarding special enrollment procedures, as follows. With the exception for a spouse's deferral of coverage explained on page 10, if you are a Non-Medicare Eligible Retiree who is participating in the Plan, and you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll the new Dependent in the Plan. However, you must request enrollment of the Dependent within thirty (30) days after the date you acquire the Dependent.

Medicare Eligible Retirees' Eligibility for Benefits

Eligibility Requirements for Medicare Eligible Retirees (except for Retirees that previously participated in the Sheet Metal Workers' Local 73 Welfare Fund Plan C for Staff)

If you are a Retiree who is eligible to enroll in Medicare, you and your Dependents may be eligible for the benefits listed in the *Schedule of Benefits* on page 7. You are not eligible for Weekly Accident and Sickness Benefits, which end on the last day of your coverage under the Sheet Metal Workers' Local 73 Welfare Fund Plan A for Active Members.

To be eligible for the benefits listed in the *Schedule of Benefits*, you must enroll in the SMW+ Plan, must make the required self-payment, must be receiving a pension from the Sheet Metal Workers' Local Union No. 73 Pension Fund (hereafter referred to as the Pension Fund or Pension Plan), and:

- The pension that you are receiving from the Pension Fund must be based on a minimum of ten (10) pension credits, but if the pension you are receiving from the Pension Fund is based on less than twenty-five (25) pension credits, you must have been credited with a minimum of three (3) pension credits within the period consisting of the Pension Plan year in which you retired and the six consecutive Pension Plan years immediately preceding the Plan Year during which you retired.
- If you have retired from a municipal or other governmental employer following a period of service that was covered under a collective bargaining agreement between such employer and the Union and are receiving a pension from the Pension Fund based on a minimum of twenty (20) but less than twenty-five (25) pension credits, you are eligible for coverage under this Plan if you are not eligible for retiree health coverage under a retiree health plan that your former municipal or governmental employer sponsors, contributes to or previously contributed to. If you subsequently become eligible for coverage under a retiree health plan that your former municipal or governmental employer sponsors, contributes to or previously contributed to, you and any enrolled dependents will lose eligibility for coverage under this Plan. For purposes of this paragraph, retiree health coverage means either self-insured or fully-insured health coverage (including but not limited to Medicare supplement coverage), including an arrangement under which the retiree has the opportunity to select one or more self-insured or fully-insured health coverage options that are partially or fully subsidized by the retiree health plan that the municipal or governmental employer sponsors, contributes to, or previously contributed to. For the avoidance of doubt, retiree health coverage shall not include a health reimbursement arrangement or health savings account arrangement that is not linked to either: (a) a self or fully-insured health plan or (b) an arrangement under which the retiree has the opportunity to select one or more self-insured or fully-insured health coverage options; retiree health coverage shall, however, include a health reimbursement arrangement or health savings account arrangement that is linked to either: (a) a self or fully-insured health plan or (b) an arrangement under which the retiree has the opportunity to select one or more self-insured or fully-insured health coverage options (which are subsidized in part or in full by the health reimbursement arrangement or health savings account). For the avoidance of doubt, if you have retired with twenty-five (25) or more pension credits from the Pension Fund, your eligibility for coverage under this Plan is not determined based on this bullet point paragraph but is determined under the other bullet point paragraphs of this section.
- If you have served as a full-time officer or business agent of the Union, you will receive credit for the years of service to the Union as if you were receiving Pension Credits for the sole purpose of determining eligibility for coverage under this Plan at the time of retirement. Service as a full-time officer or business agent of the Union will not affect eligibility for welfare coverage upon retirement since contributions are made to the Welfare Fund by the Union for such service.

For purposes of determining eligibility for benefits from this Plan, pension credits mean only those pension credits directly awarded by the Pension Fund and do not include pension credits awarded by another pension fund that are taken into consideration in regard to a Reciprocal Pension.

To enroll in the SMW+ Plan, you must complete an enrollment form and forward it to the Fund Office. The Fund Office will mail the enrollment form to the SMW+ Plan, along with a copy of your Medicare card. The Plan will pay the SMW+ premium to the Sheet Metal Workers' National Health Fund for SMW+ coverage for you and your eligible Dependents. The Trustees reserve the right to charge you for the SMW+ premium in the future.

When you retire, you have the choice of electing coverage in the Retiree Plan or electing COBRA continuation coverage with respect to your Active Employee benefits. If you choose COBRA continuation coverage with respect to your Active Employee benefits, you waive coverage under this Retiree Plan. If you choose coverage under this Retiree Plan, you waive COBRA continuation coverage. This means that if you elect either COBRA continuation coverage or coverage under the Retiree Plan, you may not at a later date choose the other type of coverage.

Continuing Eligibility for Medicare Eligible Retirees (except for Retirees that previously participated in the Sheet Metal Workers' Local 73 Welfare Fund Plan C for Staff)

If you meet the eligibility requirements for Retiree coverage, your coverage will continue if you contribute toward the cost of the Plan for yourself and your eligible Dependents. The contribution may be deducted from your Pension each month for coverage under this Plan.

Dependents who are not eligible for Medicare will continue to be covered under the Retiree Plan for Non-Medicare Eligible Retirees if they meet the eligibility requirements above and make the required self-payments. When your Dependents become eligible for Medicare, they must enroll in SMW+ in order to maintain coverage under the portion of this Plan for Medicare Eligible Retirees.

Eligibility of Dependents of Medicare Eligible Retirees (except for Retirees that previously participated in the Sheet Metal Workers' Local 73 Welfare Fund Plan C for Staff)

Eligible Dependents are defined beginning on page 12. Qualified Medical Child Support Orders (QMCSOs) are explained on page 13. Both the Dependent provisions and QMCSO provisions in the section covering eligibility for Non-Medicare Eligible Retirees also apply to eligibility of Dependents of Medicare Eligible Retirees.

Plan benefits for your Dependents will become effective on the same date you become eligible, or, if later, on the date you acquire an eligible Dependent. Benefits for your Eligible Dependents are subject to the Coordination of Benefits provision on page 97.

Termination of Eligibility for Medicare Eligible Retirees and Dependents (except for Retirees that previously participated in the Sheet Metal Workers' Local 73 Welfare Fund Plan C for Staff)

If you fail to pay the required self-payment, your coverage and coverage for your eligible Dependents will terminate at the beginning of the month for which the required self-payment was not paid.

If you fail to enroll in the SMW+ Plan, your coverage and coverage for your eligible Dependents will end and will not be reinstated.

Your Dependents will remain covered by this Plan as long as they remain your Dependents under the terms of the Plan and you meet the continuing eligibility requirements.

Special Enrollment

This Plan complies with the federal law regarding special enrollment procedures, as follows. If you are a Medicare Eligible Retiree who is participating in the Plan, and you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll the new Dependent in the Plan. However, you must request enrollment of the Dependent within thirty (30) days after the date you acquire the Dependent to receive coverage as of the date you acquire the Dependent.

Eligibility Requirements for Medicare Eligible Plan C for Staff Retirees

If you are a Retiree that previously participated in the Sheet Metal Workers' Local 73 Welfare Fund Plan C for Staff ("Plan C for Staff") who retired on or after January 1, 2022 who is eligible to enroll in Medicare, you and your spouse may be eligible for the benefits listed in the *Schedule of Benefits on page 7*. You are not eligible for Weekly Accident and Sickness Benefits or the Death Benefit, which end on the last day of your coverage under the Plan C for Staff.

To be eligible for the benefits listed in the *Schedule of Benefits,* you must enroll in the current Medicare Advantage Plan offered by the Sheet Metal Workers' National Welfare Fund, must make the required self-payment, and must satisfy at least one the following additional eligibility requirements:

- You must have at least three (3) years of service with the applicable employer through which you participated in Plan C for Staff within the consecutive six (6) year period prior to your attainment of age sixty-five (65) and have ten (10) total years of service with the applicable employer through which you participated in Plan C for Staff at the time of your retirement from employment with the applicable employer through which you participated in Plan C for Staff; or

- You must be at least age sixty-five (65) at the time of your retirement from employment with the applicable employer through which you participated in Plan C for Staff and started employment with the applicable employer through which you participated in Plan C for Staff prior to January 1, 2022.

If you are at least age sixty-five (65) at the time of your retirement and meet the eligibility requirements set forth above, you will be able to enroll in the current Medicare Advantage Plan offered by the Sheet Metal Workers' National Welfare Fund and participate in this Retiree Plan right away. If you are not at least age sixty-five (65) at the time of your retirement, you will have to wait until you attain age sixty-five (65) to enroll in the current Medicare Advantage Plan offered by the Sheet Metal Workers' National Welfare Fund and participate in this Retiree Plan.

To enroll in the Medicare Advantage Plan offered by the Sheet Metal Workers' National Welfare Fund, you must complete an enrollment form and forward it to the Fund Office. The Fund Office will mail the enrollment form to the Sheet Metal Workers' National Welfare Fund, along with a copy of your Medicare card. The Plan will pay the Medicare Advantage Plan premium to the Sheet Metal Workers' National Health Fund for the Medicare Advantage Plan coverage for you and you will be responsible for sending in the required self-payment monthly to the Fund Office at a rate set by the Trustees. The Trustees reserve the right to make changes to the required self-payment at any time and for any reason in their sole discretion.

If you are at least age sixty-five (65) when you retire, you have the choice of electing coverage in the Retiree Plan or electing COBRA continuation coverage with respect to your Active Employee benefits under Plan

C for Staff. If you choose COBRA continuation coverage with respect to your Active Employee benefits, you waive coverage under this Retiree Plan. If you choose coverage under this Retiree Plan, you waive COBRA continuation coverage. This means that if you elect either COBRA continuation coverage or coverage under the Retiree Plan, you may not at a later date choose the other type of coverage.

If you are not at least age sixty-five (65) at the time of your retirement, you have the choice of electing COBRA continuation coverage with respect to your Active Employee benefits under Plan C for Staff. Such COBRA continuation coverage does not count towards any years of service requirements for eligibility purposes. When you attain age sixty-five (65), you will be able to enroll in the current Medicare Advantage Plan offered by the Sheet Metal Workers' National Welfare Fund and participate in the Retiree Plan if you meet the eligibility requirements set forth above.

Continuing Eligibility for Medicare Eligible Plan C Staff Retirees

If you meet the eligibility requirements for Retiree coverage, your coverage will continue if you contribute toward the cost of the Plan for yourself. As indicated above, you must make the required self-payment to the Fund Office on a monthly basis.

Eligibility of Medicare Eligible Spouses of Medicare Eligible Plan C Staff Retirees

If your spouse is eligible for Medicare when you first become eligible as a Plan C Staff Retiree, he or she will be eligible for the same benefits as you. You must contribute toward the cost of the Plan for your eligible spouse and make the required self-payment to the Fund Office on a monthly basis.

If your spouse is not yet eligible for Medicare when you first become eligible as a Plan C Staff Retiree, he or she will become eligible for the same benefits as you upon becoming Medicare eligible. Therefore, when your spouse becomes eligible for Medicare, he or she must enroll in the Medicare Advantage Plan offered by the Sheet Metal Workers' National Welfare Fund in order to gain coverage under the portion of this Plan for Medicare Eligible Plan C Staff Retirees.

Eligibility of Dependents of Medicare Eligible Plan C Staff Retirees

Dependents of Medicare Eligible Plan C Staff Retirees (other than spouses who are eligible for Medicare) are not eligible for benefits.

Termination of Eligibility for Medicare Eligible Plan C Staff Retirees and Spouses

If you fail to pay the required self-payment, your coverage and coverage for your eligible spouse will terminate at the beginning of the month for which the required self-payment was not paid.

If you fail to enroll in the Medicare Advantage Plan offered by the Sheet Metal Workers' National Welfare Fund, your coverage and coverage for your eligible spouse will end under this Plan and will not be reinstated.

Your spouse will remain covered by this Plan as long as he or she remains your spouse under the terms of the Plan, and you meet the continuing eligibility requirements.

Special Enrollment

This Plan complies with the Federal law regarding special enrollment procedures, as follows. If you are a Medicare Eligible Fund Office Staff Retiree who is participating in the Plan, and you have a new spouse as

a result of marriage, you may enroll the new spouse in the Plan as long as he or she is eligible to enroll in Medicare. However, you must request enrollment of the spouse within thirty (30) days after the date you marry your spouse to receive coverage as of the date you marry the spouse.

Enrollment Procedures

Enrollment procedures are as follows:

To enroll in the Plan, complete the Benefit Enrollment Form and provide the required documentation as soon as it is available.

- **New member**: Complete the Fund's Benefit Enrollment Form, available through the Fund Office and submit a copy of your driver's license.
- **New spouse**: Submit a copy of your marriage certificate and your spouse's birth certificate to the Fund Office when you get married, along with your spouse's social security number.
- **Newborn Child**: Submit a copy of the Child's birth certificate to the Fund Office, along with your Child's social security number.
- **Newly adopted Child**: Submit a copy of the initial placement papers to the Fund Office along with a copy of the birth certificate and adoption papers (when available), along with your Child's social security number.
- **New stepchild**: Submit a copy of the stepchild's birth certificate and court decree (Qualified Medical Child Support Order) (if available) to the Fund Office, along with your Child's social security number.
- **New foster Child placed by an authorized agency or by court order, judgment or decree or any other Child for whom you may have legal guardianship by court order, judgment or decree**: Submit a copy of the court order documents signed by a judge verifying legal custody of the child (e.g., placement papers from a qualified state placement agency), or proof of judgment, decree, or court order from a court of competent jurisdiction, along with the Child's social security number.

One-Time Opt-Out Opportunity

If you wish, you may elect to cease medical and/or prescription drug coverage, as applicable, under the Plan for only yourself at any time during the Plan Year and allow your eligible Dependents, if applicable, to remain covered under the Plan. Such election shall be made by providing written notice to the Fund Office of your intention to cease coverage. Cessation of medical and/or prescription drug coverage will be effective as of the first day of the following month after the Fund Office receives such notice from you.

If you previously elected to cease your coverage for medical and/or prescription drug benefits under the Plan, you may reinstate your coverage by providing written notice to the Fund Office. Reinstatement of your medical and/or prescription drug coverage will be effective as of the first day of the Plan Year following the date the Fund Office receives such written notice from you.

This opportunity to cease coverage and be reinstated at a later time is only available to you one time.

Rescission of Coverage

A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that it will be effective back to the time that you should not have been covered by the Plan. The Plan may rescind your coverage for fraud or intentional misrepresentation of a material fact after the Plan provides you with thirty (30) days advance written notice of that rescission of coverage. However, the following situations will not be considered rescissions of coverage and do not require the Plan to give you thirty (30) days advance written notice:

- When the Plan terminates your coverage retroactive to the date you lose eligibility for coverage, if there is a delay in administrative recordkeeping between the date you lose eligibility and the date the Plan is notified of your loss of eligibility;

- When the Plan retroactively terminates your coverage because you fail to make timely self-payments for your coverage; or

- When any unintentional mistakes or errors result in you and your Dependents being covered by the Plan when you should not have been covered, the Plan will cancel your coverage prospectively – for the future – once the mistake is identified.

Continuation of Health Benefits

Continuation of Coverage After You Die

Your Dependents may continue coverage after your death, in accordance with the following rules.

Special Rules for Continuation of Coverage under the Retiree Plan for Dependents of Deceased Active Employees

If you die while you are eligible for Plan coverage as an active Employee under the Sheet Metal Workers' Local 73 Welfare Plan A for Active Members, eligibility for your Dependents will continue under Plan A for Active Members without self-contribution for as long as you would have been eligible for coverage under Plan A for Active Members, based on your accumulated eligibility.

Your Dependents may then continue coverage under this Plan, the Sheet Metal Workers' Local 73 Welfare Fund Plan for Retired Members, through this special health coverage continuation rule if:

- You died as an active Employee,
- Your accumulated eligibility under Plan A for Active Members has been exhausted,
- You had at least ten (10) pension credits awarded by the Sheet Metal Workers' Local 73 Pension Fund at the time of your death,
- You were eligible for a pension (including a Reciprocal Pension) from the Sheet Metal Workers' Local 73 Pension Fund at the time of your death, and your surviving spouse is receiving a survivor's pension as the result of your death, and
- You worked at least fifteen (15) full years with Employers that were signatories to collective bargaining agreements with the Sheet Metal Workers' International Union or one of the Sheet Metal Workers' Unions.

To be eligible to continue coverage under this Special Health Coverage Continuation provision, your surviving spouse must waive COBRA continuation coverage.

Your surviving eligible spouse and Eligible Dependent Children must make the required self-payments to the Plan for this coverage at a rate set by the Trustees. If you die prior to commencing your pension, your surviving spouse may be entitled to subsidized coverage for the first twenty-four (24) months after his or her survivor pension commences and will only be responsible for a self-payment of 5% of his or her gross monthly survivor pension amount during that initial twenty-four (24) month period. Self-payments must begin in the month following the month of your death. This special coverage is only available if your spouse was married to you throughout the twelve (12) month period immediately before your death. The Trustees reserve the right to make changes to the required self-payment at any time and for any reason in their sole discretion.

Your spouse's coverage under this provision will terminate if your surviving eligible spouse remarries following your death. If your surviving eligible spouse remarries, your spouse may elect to continue coverage for an additional thirty-six (36) month period after remarriage. This coverage will be the same coverage the surviving spouse received under the Special Health Coverage. Continuation provisions, will be offered at the COBRA rate of coverage, but will not constitute COBRA coverage.

Coverage will terminate for your surviving Dependent Child who continues coverage under the Special Health Coverage Continuation provisions when the Dependent Child no longer meets the definition of

Eligible Dependent under the Plan. The Dependent Child may elect COBRA continuation coverage for up to thirty-six (36) months from the date the Child no longer meets the definition of an Eligible Dependent.

If you die as an active Employee without meeting the requirements of this provision, your surviving eligible spouse and Eligible Dependent Children will be entitled to COBRA continuation coverage only.

If your surviving eligible spouse is receiving a pension from the Sheet Metal Workers' Local 73 Pension Fund, there is no continuation of eligibility under the Sheet Metal Workers' Local 73 Welfare Fund Plan A for Active Members and self-payments for Retiree Plan benefits must begin immediately.

Except in limited circumstances for surviving spouses entitled to subsidized coverage for the first twenty-four (24) months after commencement of a survivor pension, the premium for coverage is based upon the surviving eligible spouse's age. The rate will generally be decreased when the surviving spouse reaches age 60, again when the surviving spouse reaches age 62, and again when the surviving spouse reaches age 65. If the surviving spouse remarries, the Eligible Dependent Children's coverage will continue under the Special Health Coverage Continuation provisions until each Child reaches the limiting age.

Continuation of Coverage for Dependents of Deceased Retirees

If you die while you are eligible for Retiree coverage, eligibility for your Dependents will continue to the end of the month in which you die, and then your surviving Dependents may elect to continue coverage under the Retiree Plan.

To be eligible to continue coverage under this provision, your surviving spouse must waive COBRA continuation coverage, except that if your surviving spouse remarries within thirty-six (36) months of your death, Special Continuation Coverage will end, but your surviving spouse may elect COBRA continuation coverage under the Retiree Plan for the surviving spouse and Dependent Children for the balance of the thirty-six (36) month period that begins on the date of your death.

Your surviving spouse and Eligible Dependent Children must make the required self-payments to the Plan for this continuation coverage at a rate set by the Trustees. Self-payments must begin in the month following the month of your death. This coverage is only available if your surviving spouse was married to you throughout the twelve (12) month period immediately before your death.

Coverage provided to your surviving spouse and Dependent Children under this provision will terminate if your surviving spouse remarries following your death. Coverage for your surviving spouse who remarries and any covered Dependent Children will terminate at the end of the month in which your surviving spouse remarries. However, your surviving spouse and any covered Dependent Children will be entitled to elect COBRA continuation coverage under the Retiree Plan for the remainder of the thirty-six (36) month period that started on the date of your death by making timely self-payments at the COBRA rate of coverage. If your surviving spouse does not remarry, coverage will terminate for a Dependent Child who continues coverage under these provisions when the Dependent Child no longer meets the definition of Eligible Dependent under the Plan. The Dependent Child may elect COBRA continuation coverage under this Retiree Plan for up to thirty-six (36) months from the date the Child no longer meets the definition of an Eligible Dependent.

The premium for coverage is based upon your surviving spouse's age. The rate will generally be decreased when your surviving spouse reaches age 60, again when your surviving spouse reaches age 62, and again when your surviving spouse reaches age 65. If your surviving spouse remarries, your Eligible Dependent Children's coverage will continue under these provisions until each Child reaches the limiting age.

COBRA Continuation Coverage

When coverage under the Plan would otherwise end, your Dependents may be able to continue coverage by electing COBRA continuation coverage.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides for continuation of health coverage for your spouse and Dependent Children if you lose coverage under the Plan due to a qualifying event. Your Dependents may continue health coverage for a limited period by making self-payments to the Plan.

If your Dependents lose eligibility because of the qualifying event of your death, your entitlement to Medicare, divorce or legal separation, or loss of Dependent status, they may elect COBRA continuation coverage.

You and your Dependents may choose individual coverage or family coverage.

Eligibility for COBRA Continuation Coverage

If your Dependents are eligible for COBRA continuation coverage, they are considered qualified beneficiaries, meaning they were covered by the Plan on the day before the qualifying event.

COBRA continuation coverage allows your Dependents to pay to continue your coverage when it would otherwise end. Dependents may be eligible to elect COBRA continuation coverage if they experience a qualifying event.

If your Dependents marry, have a newborn Child, or have a Child placed with them for adoption while they are enrolled in COBRA continuation coverage, they may enroll that spouse or Child for the balance of the period of their coverage. They must complete the enrollment within thirty (30) days after the birth, marriage, or placement for adoption. These Dependents who are added to your Dependent's COBRA coverage will have COBRA coverage but will not have all of the rights of a qualified beneficiary (such as adding additional beneficiaries).

Scope of COBRA Continuation of Coverage

If your Dependents choose COBRA continuation coverage, they are entitled to the same type of coverage that they had on the day before the date of the event that triggered COBRA. If there is a change in the health coverage, including Prescription Drug coverage that is provided by the Plan to similarly situated Participants, that same change will be made to COBRA continuation coverage.

Qualifying Events That Trigger COBRA Continuation Coverage

If your Dependents experience a qualifying event that causes them to lose coverage, they will be considered qualified beneficiaries, and the Fund will send them a COBRA Election Notice and a form for them to elect coverage. The qualifying events under which your Dependents may lose coverage under the Plan and the period for which they may make self-payments to continue benefits are described below.

Your spouse becomes a qualified beneficiary if he or she loses coverage because any of the following qualifying events:

- Your death,
- You and your spouse become divorced or legally separated, or
- You become entitled to Medicare benefits under Part A, Part B or both. Becoming entitled to Medicare means that you: 1) were eligible for Medicare benefits, and 2) enrolled in Medicare (under Part A, Part B, or both). The entitlement date is the date of enrollment in Medicare.

Your Eligible Dependent Children become qualified beneficiaries if they lose coverage because any of the following qualifying events:

- Your death,
- The Child's parents become divorced or legally separated,
- The Child stops being eligible for coverage under the Plan as an Eligible Dependent Child, or
- You become entitled to Medicare benefits under Part A, Part B or both. Becoming entitled to Medicare means that you: 1) were eligible for Medicare benefits, and 2) enrolled in Medicare (under Part A, Part B, or both). The entitlement date is the date of enrollment in Medicare.

Length of COBRA Continuation Coverage

If your Dependents lose coverage under the Plan because of divorce, legal separation, your death, or loss of Dependent status, your Dependents may maintain COBRA continuation coverage for a maximum period of thirty-six (36) months from the date coverage was lost.

Cost of and Payment for COBRA Continuation Coverage

Any qualified beneficiary who elects COBRA continuation coverage will pay the full cost of the coverage. The Fund can charge the full cost of coverage for similarly situated Retirees and their families (including both the Fund's share and Retiree's share, if any) plus an additional 2%.

The monthly cost depends on how many people are covered. Rates are provided for one person or for family coverage. If a qualified beneficiary adds Dependents that are acquired during the COBRA continuation coverage period and the qualified beneficiary was previously paying for individual coverage, the qualified beneficiary will be required to pay the higher rate.

The Trustees will establish the COBRA continuation coverage rates in accordance with ERISA and the Internal Revenue Code, the laws that govern the Plan. Generally, the Trustees will set new rates each Plan Year beginning July 1.

When you elect COBRA continuation coverage, you are required to make the first payment no later than forty-five (45) days after the date of your election, which is the date your COBRA Election Notice is post-marked, if mailed. If you do not make the first payment for continuation coverage in full within the forty-five (45) day deadline after your election, you will lose all rights to COBRA continuation coverage. You are responsible for contacting the Fund Office to make sure that the amount of your first payment is correct.

Your subsequent payments for COBRA continuation coverage are due on the first day of the month for which coverage is being provided. However, you have a thirty (30) day grace period to make the payment. If the payment is not made when due, you will lose all continuation coverage rights under the Plan. COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the month for which it applies, but before the end of the grace period (the end of the month) for the coverage, coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated, going back to the first day of the month when your payment is received.

COBRA Continuation Coverage Notice and Election

You or your covered family member must inform the Fund Office of a divorce, legal separation, or a Child losing Dependent status. **You or your Dependent must provide written notice within sixty (60) days of the event or the person affected forfeits the right to COBRA continuation coverage**.

Your surviving Dependent spouse or Child should notify the Fund Office of your death within thirty (30) days of the date that your surviving Dependents would otherwise lose coverage due to your death.

When the Fund Office is notified that one of these events has occurred, it will in turn notify your Dependents of the right to choose continuation coverage and the time frame within which they must make the election. If your Dependents are not entitled to COBRA continuation coverage, the Fund will notify them of their ineligibility in writing.

If your Dependent's coverage ends due to divorce, legal separation, or loss of Dependent status, you or your Dependent must notify the Fund Office within sixty (60) days of the event to qualify for COBRA continuation coverage.

Your Dependents have an election period of at least sixty (60) days from the date the notice is provided to inform the Fund Office of their election of COBRA continuation coverage.

Your Dependents may elect individual coverage or family coverage. Once they make an election for COBRA continuation coverage, they cannot change it *unless it is within the sixty (60) day election period*. This means that after the sixty (60) day election period ends, if they elect individual coverage, they cannot change to family coverage (except as explained in the next sentence), and if they elect family coverage, they cannot change to individual coverage. However, if they elect family coverage for only two family members and one of the family members dies, and individual coverage would be less expensive, the surviving individual may change to individual coverage. The Plan will charge for the individual premium starting on the first day of the month following the day the covered family member dies.

COBRA Benefit Coverage

Under COBRA continuation coverage, your Dependents are entitled to the same type of coverage that they had on the day before the date of the event that triggered coverage. If your Dependents choose COBRA continuation coverage and make the required self-payments, the Welfare Fund will provide coverage for all medical, dental, prescription drug, wellness, Substance Abuse, hearing, and vision benefits under the Plan.

In addition, if there is a change in the healthcare coverage that is provided by the Plan to Retired Participants, that same change will be made to the COBRA continuation coverage of qualified beneficiaries.

Termination of COBRA Continuation Coverage

If your Dependent elects COBRA continuation coverage, coverage will terminate as of the date the first of any of the following events occur:

- Your Dependents do not pay the self-payment for COBRA continuation coverage within thirty (30) days of its due date.
- Your Dependents become covered under another group health plan. Contact the Fund Office for details.
- Your Dependents become eligible for Medicare. Contact the Fund Office for details.
- The Welfare Fund no longer provides any healthcare benefits.

Availability of Other Coverage Besides COBRA Continuation Coverage

There may be other coverage options for you and your family besides COBRA continuation 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 could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may have coverage options under Medicare, Medicaid, Children's Health Insurance Program (CHIP) or you may qualify for a special enrollment opportunity 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 enrollees, if you request enrollment within thirty (30) days.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact Patrick Ludvigsen, Fund Administrator, at 708-449-7373, or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa/.

Keep the Fund Informed of Address Changes

In order to protect your family's rights, you should keep the Fund informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund.

Utilization Management

Your Plan has adopted a Utilization Management Program designed to help control increasing health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result. By doing this, the Fund is better able to afford to maintain the Plan and all its benefits. If you follow the procedures of the Plan's Utilization Management Program, you may avoid some out-of-pocket costs. However, if you don't follow these procedures, you will be responsible for paying more out of your own pocket.

The UM Company focuses its review on the necessity and appropriateness of hospital stays and the necessity, appropriateness and cost-effectiveness of proposed medical, surgical other services. In carrying out its responsibilities under the Plan, the UM Company has been given discretionary authority by the Plan Administrator to determine if a course of care or treatment is Medically Necessary with respect to the patient's condition and within the terms and provisions of this Plan.

The Plan's Utilization Management Program consists of:

1. ***Precertification review:*** review of proposed services before the services are provided;
2. ***Concurrent review:*** ongoing assessment of the care as it is being provided, typically involving inpatient admissions;
3. ***Second and third opinions:*** consultations and/or examinations designed to take a second, and, when required, a third look at the need for certain elective health care services;
4. ***Retrospective review:*** review of services after they have been provided; and
5. ***Case Management:*** a process where You or your eligible Dependent, and/or providers work together under the guidance of the Plan's independent Utilization Management Company to coordinate a quality, timely and cost-effective treatment plan. Case Management services may be particularly helpful for patients who require complex, high-technology medical services and who may therefore benefit from professional assistance to guide them through the maze of choices of health care services, providers and practices.

No Guarantee of Payment

1. The fact that your Health Care Provider recommends Surgery, Hospitalization, confinement in a Health Care Facility, or that your Health Care Provider proposes or provides any other medical services or supplies doesn't mean that the recommended services or supplies will be an Covered Expense or be considered Medically Necessary for determining coverage under the Plan.
2. The Utilization Management Program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. The UM Company's certification that a service is Medically Necessary doesn't mean that a benefit payment is guaranteed. Eligibility for and actual payment of benefits are subject to the terms and conditions of the Plan.
3. All treatment decisions rest with you and your Provider. You should follow whatever course of treatment you and your Health Care Provider believes to be the most appropriate, even if the UM Company does not certify a proposed surgery/treatment/service or admission as Medically Necessary. However, the benefits payable by the Plan may be affected by the determination of the UM Company.

Pre-Certification:

You should contact the Fund Office if you have any questions regarding the precertification process or if you are unsure if a service or treatment must be pre-certified.

The following services require pre-certification and medical review:

- Durable Medical Equipment as provided in Appendix A
- Skilled Nursing Care
- All Elective Hospital Admissions
- All Elective In-Patient Admissions (For Medical and Mental Health and Substance Used Disorder Admissions)
- All Elective Surgery and/or Surgical Procedures
- Hospice Benefits
- Private Duty Nursing/Coordinated Home Care Program
- Growth Hormones for Dependent Children
- Physical and Occupational Therapy beginning when you need 30 visits or more in a calendar year, pre-certification required after 30th visit.

Emergency Hospitalization or Inpatient Mental Health or Substance Use Disorder Treatment

If an emergency requires hospitalization, there may be no time to contact the UM Company before you are admitted. If this happens, the UM Company must be notified of the hospital admission within 48 hours. You, your Health Care Provider, the hospital, a family member or friend can make that phone call to the UM Company. This will enable the UM Company to assist you with your discharge plans, determine the need for continued medical services, and/or advise your providers of the various benefits available for you and offer recommendations, options and alternatives for your continued care.

Concurrent Review

1. When you are receiving medical services in a hospital or other inpatient facility, the UM Company will monitor your stay by contacting your Providers to assure that continuation of medical services in the facility is Medically Necessary, and to help coordinate your care with benefits available under the Plan.
2. Concurrent review may include such services as coordinating home health care or durable medical equipment, assisting with discharge plans, determining the need for continued medical services; and/or, advising your Providers of various options and alternatives for your care available under this Plan.
3. You or your eligible Dependent may be denied payment if services or treatment are found to be not medically necessary or not covered under the Plan.

Second or Third Opinion

At any time during the review process, you may be asked by the UM Company to obtain an additional

opinion about a proposed service to help determine if the service is Medically Necessary, or if an alternative effective approach to your or your Dependent's care management exists.

Retrospective Review

Claims for services or supplies that have not been reviewed under the Plan's Precertification, Concurrent Review, or Second and Third Opinion Programs may be subject to retrospective review to determine if they are Medically Necessary. If the Plan receives a determination from a UM Company that services or supplies were not Medically Necessary, the Plan may deny benefits.

Case Management

Case Management is a voluntary process, administered by the UM Company. Case Management services are particularly helpful when you or your eligible Dependent needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential Providers.

You, your eligible Dependent, or Provider can request Case Management services by calling the UM Company. However, the UM Company will actively search for those cases where you or your eligible Dependent could benefit from Case Management services, and it will initiate Case Management services automatically.

The Case Manager of the UM Company will work directly with your Provider, Hospital, and/or other facility to review proposed treatment plans and to assist in coordinating services, locating in-network providers, and providing other services as needed. From time to time, the Case Manager may confer with your Provider, and may contact you or your Dependent to assist in making plans for continued care and to assist you or your Dependent in obtaining information to facilitate those services.

You may call the Case Manager of the Utilization Management Company or the Fund Office at any time to ask questions or obtain information.

Appeals

You may request an appeal of any adverse review decision made during the precertification, concurrent review, retrospective review, Case Management or second opinion review process.

Comprehensive Major Medical Benefit (For Non-Medicare Eligible Retirees Only)

The Fund helps you and your family pay for healthcare expenses as described in this section. If you or your Dependents incur covered expenses during any calendar year, the Plan will pay the percentages of such covered expenses as listed in the Schedule of Benefits on page 4. Covered expenses do not include expenses for work-related accidents, Injuries or Sickness.

Preferred Provider Organization (PPO)

The Fund provides comprehensive medical coverage through Blue Cross Blue Shield of Illinois, a Preferred Provider Organization (PPO) that has agreed to provide medical services to you and your Dependents at pre-negotiated rates.

Preferred Provider Organization (PPO)

PPO network Providers are healthcare Providers who participate in the PPO network and have agreed to charge negotiated rates.

The Plan generally pays a higher percentage of covered expenses when you use a network Provider.

You are encouraged to use PPO Hospitals and Physicians whenever possible. You will receive the maximum benefits available under the Fund when you use PPO Providers because the Fund will be paying a greater percentage of your covered expenses. Your share will also be less because those covered expenses are generally billed at a discount by the PPO.

To select a PPO Provider in your area or to find out whether your Provider is in the PPO network, you may contact Blue Cross Blue Shield of Illinois, free of charge, at 1-800-810-BLUE (2583), visit the Blue Cross Blue Shield of Illinois website at www.bcbsil.com or call the Fund Office at 1-708-449-7373. Have your medical ID card handy so that you can provide any information required about your Fund.

Calendar Year Deductible

Each calendar year, before the Plan begins to pay benefits, you must pay the individual deductible listed in your *Schedule of Benefits* on page 4. Your family meets the deductible when three (3) family members have paid their individual deductibles during the calendar year. After that, no other covered family members will have to meet the individual deductible.

The deductible applies only once in a calendar year even though you may have several different Sicknesses or Injuries during that period. So that your medical claims will not be subject to a deductible late in one (1) calendar year and soon again in the following year, any expenses applied against the deductible in the last three (3) months of a calendar year may also be applied against the deductible for the next calendar year.

When you use a Blue Cross Blue Shield Center of Excellence facility to receive transplant benefits, you are not required to pay the deductible for these expenses. You also do not need to satisfy the deductible before being eligible for Hospice benefits.

Common Accident

If two (2) or more eligible family members are injured in the same accident, only one (1) deductible will apply in the current and next succeeding calendar year for all their covered expenses directly resulting from the accident.

Coinsurance

You and the Fund share your healthcare expenses. Coinsurance is:

- The amount that the Plan pays of your eligible expenses after you have paid your deductible, and
- Listed in the *Schedule of Benefits* on page 4 as a percentage of your eligible expenses, after the deductible.

When you use a Blue Cross Blue Shield Center of Excellence facility to receive transplant benefits, the Plan's coinsurance provisions do not apply to your transplant expenses. The coinsurance provisions also do not apply to Hospice benefits.

Out-of-Pocket Maximum

Each calendar year after you reach the out-of-pocket maximum per person listed in the *Schedule of Benefits* on page 4, the Plan generally pays 100% of your remaining covered expenses during that calendar year, except for the following expenses:

The deductible does not count toward the out-of-pocket maximum.

- Treatment for infertility,
- Treatment received at a non-PPO Hospital, a non-PPO Ambulatory Surgical Facility, or treatment received from a non-PPO Physician, and

The following expenses are not counted toward the out-of-pocket maximum:

- Treatment received at a non-PPO Hospital, a non-PPO Ambulatory Surgical Facility, or treatment performed by a non-PPO Physician, and
- Treatment received for infertility.

Pre-Admission Authorization

When your Physician recommends elective or non-emergency hospitalization or Inpatient surgery, you should call Valenz Care for prior approval of the admission at least one (1) business day before you go into the Hospital. Contact Valenz Care at 1-800-367-1934.

If you have an emergency admission, you, your Physician, the Hospital or a family member should call Valenz Care within two (2) business days of the date of your admission. This provision does not apply to maternity admissions.

Pre-admission authorization is not a guarantee that all services and charges will be paid for by the Fund. Your benefits are still subject to the terms and conditions of the Plan.

The Fund provides coverage for physician office and mental health counseling tele-visits and video visits in the same way as any other in-person office visit and subject to the same cost-sharing (e.g., deductibles, coinsurance, or copayments) to the extent they are Reasonable and Customary Charges and it is appropriate to provide such services via tele-visit or video visit. In no event will the Fund provide coverage for tele-visits or video visits related to physical therapy or chiropractic care.

Covered Expenses

The Plan provides a wide variety of services and supplies that are Medically Necessary for treatment of non–work-related Sickness and Injuries, unless they are excluded or limited by another Plan provision. These include medical care by Hospitals, Doctors and other healthcare Providers, as well as diagnostic tests and procedures used in treatment. Certain benefits must be approved by Valenz Care or the Fund Office and its Contracted Medical Claim Review Provider. In the event the service or procedure is not covered by the *Schedule of Benefits*, it will not be covered.

The following expenses are covered under the Comprehensive Major Medical Benefit if they are Reasonable and Customary Charges, are Medically Necessary (see the *Definitions* Section beginning on page 109) and are services and supplies provided for the treatment of non-occupational Sicknesses or Injuries:

1. Hospital charges for daily board and bed or room, up to the Hospital's regular daily rate for semi-private accommodations. The Plan will cover the expense of a private room if semi-private accommodations are not available.
2. Hospital specialty care unit charges (intensive care unit or cardiac care unit).
3. Charges, other than charges for regular daily services, made by a Hospital for medical care and treatment, exclusive of charges for professional services, including Medically Necessary ancillary services (e.g., prescriptions, supplies).
4. Ambulatory Surgical Facilities expenses.
5. Professional local ambulance service charges for transportation to a Hospital. Transportation by air ambulance is covered if Medically Necessary.
6. Charges made by a licensed Physician for medical care and treatment and for performing a surgical procedure or a laparoscopic procedure.
7. Charges made by a Registered Nurse (RN) during Hospital confinement for private nursing service, provided the attending Physician prescribes in writing the need for services of an RN. In addition, only a coordinated home-care program provided by an RN that is Medically Necessary (not custodial-type care) and that replaces or reduces confinement in a Hospital or Skilled Nursing Facility will be covered.
8. Charges made by a person who is legally licensed as a Licensed Practical Nurse (LPN) during Hospital confinement, provided that an RN is not available and the attending Physician prescribes the services of an LPN. In addition, services of an LPN for home care will be covered if the services are Medically Necessary and are rendered under the direction of a Physician or RN.
9. Charges made for the cost and personal administration of an anesthetic by a Physician who remains in constant attendance during a surgical procedure for the sole purpose of rendering an anesthetic.
10. Charges made for the cost and personal administration of an anesthetic by a person legally licensed as a Certified Registered Nurse Anesthetist (CRNA) under the supervision of a Physician who remains in constant attendance during a surgical procedure for the sole purpose of rendering an anesthetic. A CRNA includes a person legally licensed as a CRNA, Registered Nurse Anesthetist, or Nurse Anesthetist, who is authorized to administer anesthesia in collaboration with a Physician, and bill and be paid in the Nurse Anesthetist's own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of the

Nurse Anesthetist's license and who is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

11. Residential treatment centers/facilities for behavioral healthcare, including substance abuse.

12. Charges made for radium therapy, X-ray treatments and examinations, microscopic tests or any laboratory tests or analyses made for diagnostic or treatment purposes. No benefits will be payable for dental X-rays or X-rays for eye refractions, except in cases of bodily Injury.

13. Charges made for treatment by a person legally licensed as a professional physical, occupational, or speech therapist who acts within the scope of his/her license. Physical, occupational, and speech therapy are benefits that can be subject to medical review after the 30th visit in the calendar year. Please contact Valenz Care after the 30th visit for utilization review.

14. Charges made by a person legally licensed as a doctor of chiropractic medicine (DC) who acts within the scope of his/her license, as provided in the *Schedule of Benefits* on page 5 and subject to a calendar year maximum shown in the *Schedule of Benefits*.

If you need to see a Physician:

- Call to make an appointment.
- Write down any questions you may have before your appointment. This way, you will not forget to ask your Physician important questions during your appointment.
- Make a list of any medications you're taking. Be sure to note how often you take the medications.
- Show your ID card when you go to your appointment.
- All claims should be submitted to Blue Cross Blue Shield of Illinois, including non-network Hospital or Provider claims. Make a copy of the claim form and any supporting materials for your records before submitting the claim.

15. Charges made by a person legally licensed as a doctor of osteopathic medicine (DO) who acts within the scope of his/her license, in accordance with the *Schedule of Benefits* on page 4.

16. Charges made by a Physician for Inpatient or Outpatient treatment of Mental or Nervous Disorders and/or Substance Abuse.

17. Charges made by a Dentist for the performance of oral surgery, consisting of cutting procedures for the treatment of diseases or injuries of the jaw or extraction of impacted teeth, provided that such oral surgery is performed during a period of confinement of at least eighteen (18) hours in a legally constituted and operating Hospital.

18. Cochlear Implants (preauthorization required), as provided in the *Schedule of Benefits* on page 4.

19. FDA-approved contraceptives methods, sterilization procedures, and patient education and counseling for women of reproductive capacity. FDA-approved contraceptive methods include barrier methods, hormonal methods, and implanted devices, as well as patient education and counseling, as prescribed by a Health Care Provider. The Plan may cover a generic drug without cost sharing and charge cost sharing for an equivalent branded drug. The Plan will accommodate any individual for whom the generic would be medically inappropriate, as determined by the individual's Health Care Provider. Services related to follow-up and management of side effects, counseling for continued adherence, and device removal are also covered without cost sharing.

20. Gastric By-pass Procedures to treat morbid obesity, provided the following criteria are met:

    a) The patient's Body Mass Index (BMI) is greater than or equal to fifty (50), or

    b) The patient's BMI is greater than or equal to forty-five (45) with two (2) or more co-morbidities that immediately endanger the patient's well-being. Co-morbidities include hypertension, diabetes, dyslipidemia, sleep apnea and coronary heart disease.

c) The Gastric By-pass Procedure must be performed by a PPO Physician at a PPO surgical facility. The Plan will make no payment for Gastric By-pass Procedures that are performed by a non-PPO Physician or for Gastric By-pass Procedures that are performed at a non-PPO facility.

21. Genetic Testing (see the Definitions section starting on page 109), as required by the Affordable Care Act.

Genetic tests include, but are not limited to:

a) A test to determine whether someone has the BRCA1 or BRCA2 variant evidencing a predisposition to breast cancer, a test to determine whether someone has a genetic variant associated with hereditary nonpolyposis colon cancer, and a test for a genetic variant for Huntington's Disease;

b) Carrier screening for adults using genetic analysis to determine the risk of conditions such as cystic fibrosis, sickle cell anemia, spinal muscular atrophy, or fragile X syndrome in future offspring;

c) Amniocentesis and other evaluations used to determine the presence of genetic abnormalities in a fetus during pregnancy;

d) Newborn screening analysis that uses DNA, RNA, protein, or metabolite analysis to detect or indicate genotypes, mutations, or chromosomal changes, such as a test for PKU performed so that treatment can begin before a disease manifests;

e) Preimplantation genetic diagnosis performed on embryos created using in vitro fertilization;

f) Pharmacogenetic tests that detect genotypes, mutations, or chromosomal changes that indicate how an individual will react to a drug or a particular dosage of a drug;

g) DNA testing to detect genetic markers that are associated with information about ancestry; and

h) DNA testing that reveals family relationships, such as paternity; and

i) A test to determine whether an individual has a genetic predisposition for alcoholism or drug use.

Genetic Information Nondiscrimination Act (GINA) prohibits group health plans, issuers of individual health care policies, and Employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about:

a) Such individual's genetic tests;

b) The genetic tests of family members of such individual; and

c) The manifestation of a Disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include Dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions, and applying preexisting conditions. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a Health Care Provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

See Appendix A on page 116 for a detailed listing of covered Durable Medical Equipment and a listing of what is not covered.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

22. Rental or, if approved by Valenz Care, the purchase of Durable Medical Equipment (DME) which is Medically Necessary for treatment of a Sickness or Injury. To be eligible for coverage:

    a) The equipment must meet the Plan's definition of DME.

    b) The equipment must be ordered by a Physician who must certify the necessity of the equipment and indicate how long the equipment will be needed. This written order must be submitted to the Fund Office and must include a complete diagnosis and treatment plan so the Fund Office can determine whether purchase or rental of the Medically Necessary equipment is more cost-effective.

    c) You must submit an itemized bill from the company supplying the equipment showing the date the equipment was delivered and the full rental or purchase price.

    The Plan will cover one item of the same or similar DME every five (5) years (measured from the DME's initial rental or purchase date) for each eligible person.

    The items listed in Appendix A on page 116 are considered DME or covered supplies for which benefits may be payable if all other conditions to entitlement are satisfied. The items listed as *Non-Covered* on page 116 are not considered DME or a covered supply.

    The Trustees will have the authority and discretion to determine what is considered DME and covered supplies for items not listed and when to rent, lease or purchase the equipment.

    For the purpose of determining the Reasonable and Customary Charge for the purchase of DME, the Trustees may ascertain the wholesale cost of the *basic model* for the same or similar equipment.

    The Trustees have the authority to authorize additional payment if, in their opinion, such additional payment is reasonable.

Repairs of DME are not considered covered expenses.

23. Radiation therapy and chemotherapy treatments.

24. Renal dialysis treatments are covered if you receive them in a Hospital, a Plan Approved Dialysis Facility or in your home under the supervision of a Hospital or Plan Approved Dialysis Facility.

25. Skilled Nursing Facility Care.

    a) Admission to a Plan/PPO Skilled Nursing Facility is considered a continuation of your Inpatient Hospital stay and payment will be the same as that previously described for Inpatient covered services.

    b) If you have been hospitalized, you may continue your recovery as an Inpatient in a Skilled Nursing Facility. You must be admitted for the same diagnosis as the Hospital admission within fourteen (14) days of leaving the Hospital or a coordinated home-care program.

    Services must be received in a Plan/PPO Skilled Nursing Facility. Benefits are not available for services received in a Non-Plan Skilled Nursing Facility. Contact the Fund Office before admission to a Skilled Nursing Facility to verify that the facility is a Plan/PPO Skilled Nursing Facility (see the *Definitions* section on pages 114 and 115).

    You should verify that a Skilled Nursing Facility is a Plan/PPO Skilled Nursing Facility before admission.

    c) Covered services in a Plan/PPO Skilled Nursing Facility include:

        (i) Bed, board and general nursing care.

        (ii) Ancillary services (such as drugs and surgical dressings and supplies).

26. Pre-Admission Testing.

27. Human Organ Transplants. Benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ or tissue transplants. Benefits are available to both the recipient and donor of a covered transplant as follows:

    a) The Fund's deductible and coinsurance provisions do not apply to expenses of covered transplants received at Blue Cross Blue Shield Centers of Excellence facilities.

    b) If both the donor and recipient have coverage, each will have their benefits paid by their own program.

    c) If you are the recipient of the transplant and the donor for the transplant has no coverage from any other source, the benefits described in this benefit booklet will be provided for both you and the donor. In this case, payments made for the donor will be charged against the recipient's benefits.

    d) If you are the donor for the transplant and no coverage is available to you from any other source, the benefits described in this benefit booklet will be provided for you; however, no benefits will be provided for the recipient.

    e) In addition to the above provisions, benefits for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants will be provided as follows:

        (i) Benefits under this coverage will begin no earlier than five (5) days prior to the transplant surgery and will continue for a period of no longer than three hundred sixty-five (365) days after the transplant surgery. Benefits will be provided for all

Inpatient and Outpatient covered services related to the transplant surgery in accordance with the *Schedule of Benefits* on page 5.

(ii) Benefits will also be provided for the transportation of the donor organ to the location of the transplant surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada.

f) In addition to the other exclusions of this benefit booklet, benefits will not be provided for the following:

(i) Cardiac rehabilitation services when not provided to the transplant recipient within three (3) days after discharge from a Hospital for transplant surgery.

(ii) Transportation by air ambulance for the donor or the recipient.

(iii) Travel time and related expenses required by the Provider.

(iv) Drugs that are investigational, as determined by Valenz Care.

28. Maternity services as follows:

a) Benefits provided for you and your Dependents including your Dependent Child.

b) Benefits for maternity services are the same as benefits for any other condition.

c) Benefits will be paid for covered services received in connection with both normal pregnancy and complications of pregnancy. Maternity service benefits will also be provided for the routine Inpatient nursery charges (such as room and board, infant feedings, etc.). Coverage also includes benefits for elective abortions if legal where performed.

d) Your Eligible Dependent Child is covered for prenatal and delivery expenses incurred as a result of the birthing process only. No other maternity or newborn charges will be considered covered expenses for your Dependent Child or the newborn Child.

e) Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery or less than ninety-six (96) hours following a Cesarean Section. However, Federal law generally does not prohibit the mother's or newborn's attending Physician, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans and issuers may not require that a Provider obtain authorization from the Fund or the insurance issuer for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six) 96 hours).

f) Home birth by licensed midwife.

29. The necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of your newborn Child. In addition, benefits will be payable with respect to expenses incurred as a result of routine nursing care, routine well baby care, immunizations and medical exams or tests.

30. Administration of blood transfusions.

31. Surgical sterilization charges.

32. Routine child and adolescent immunizations and routine Physician examinations or check-ups (through the end of the month of the Child's 26th birthday) for eligible Dependents.

Routine immunizations are covered for your Eligible Dependent Children through the end of the month that they turn age 26.

33. If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:
:

    a) All stages of reconstruction of the breast on which the mastectomy was performed;

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

    c) Prostheses; and

    d) treatment of physical complications of the mastectomy, including lymphedemas.

34. Hospice expenses, in accordance with the Hospice Benefit on page 42.

35. Infertility treatment including in vitro fertilization (IVF), embryo transfer, artificial insemination (AI), interine embryo lavage, gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), lower tubal transfer, (PESA) sperm retrieval after vasectomy and Prescription Drugs related to the treatment of infertility, subject to the limits contained in the *Schedule of Benefits* on page 5.

36. Vision therapy to improve and correct vision problems rendered by an optometrist or orthoptic technician for certain limited conditions. The diagnosis must indicate a structural or physical disorder of the eye or eye muscles, such as:

    a) Accommodation inability (non-presbyopic),

    b) Amblyopia (resulting from disuse/exanopsia), and

    c) Binocular dysfunction, including:

        (i) Convergence/divergence insufficiency (heterophorias: esophoria and exophoria),

        (ii) Strabismus, accommodative (heterotropias: esotropia and exotropia), and

        (iii) Myopia, functional (excessive convergency).

35. Emergency Services with respect to an Emergency Medical Condition (defined below), which means a medical screening examination within the emergency department of a Hospital, including ancillary services routinely available to 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 at the Hospital to stabilize the patient.

    a) The term "to stabilize" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an Emergency Medical Condition, to deliver a newborn child (including the placenta).

    b) The term Emergency Medical Condition means a medical condition 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 medical attention to result in serious jeopardy to the health of the individual (or for a pregnant woman, the health of the woman or her unborn child), serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

36. The first pair of eyeglasses purchased after cataract surgery.

37. Charges for certain Health Care Providers, which include the following:

a) Charges made by a Physician Assistant (PA) who meets all of the following requirements:

(i) who is legally licensed as a PA in the State in which services are furnished;

(ii) who acts within the scope of his or her license;

(iii) who is not the patient or the parent, spouse, sibling (by birth or marriage), or child of the patient; and

(iv) who acts under the supervision of a Physician.

Coverage is limited to services that are of the type that would be considered physician's services if furnished by a Physician and that a PA is legally authorized to perform under applicable State law.

b) Charges made by a Nurse Practitioner (NP) who meets all of the following requirements:

(i) who is a registered professional nurse authorized by the state in which the services are furnished to practice as an NP;

(ii) who is certified as an NP by a recognized national certifying body that has established standards for NPs;

(iii) who has a master's degree in nursing; who acts within the scope of his or her license;

(iv) who is not the patient or the parent, spouse, sibling (by birth or marriage), or child of the patient; and

(v) who acts in collaboration with a Physician.

Coverage is limited to services that would be considered physician's services if furnished by a physician and that a NP is legally authorized to perform under applicable State law.

c) Charges made by a Certified Nurse-Midwife (CNM) who meets all of the following requirements:

(i) is licensed to practice in the state in which the services are furnished as a registered professional nurse;

(ii) who is either (A) legally authorized in the state to practice as a nurse-midwife and has completed a program of study and clinical experience for nurse-midwives as specified by the applicable state, or (B) if the applicable state does not specify a program of study and clinical experience for nurse-midwives, then the nurse-midwife must either (1) be currently certified as a nurse-midwife by the American College of Nurse-Midwives, (2) have satisfactorily completed a formal education program (of at least one (1) academic year) that, upon completion, qualifies the nurse to take the certification examination offered by the American College of Nurse-Midwives, or (3) have successfully completed a formal education program for preparing RNs to furnish gynecological and obstetrical care to women during pregnancy, delivery, and the postpartum period, and care to normal newborns, and have practiced as a nurse-midwife for a total of twelve (12) months during any eighteen (18) month period from August 8, 1976 to July 16, 1982;

(iii) who acts within the scope of his or her license; and

(iv) who is not the patient or the parent, spouse, sibling (by birth or marriage), or child of the patient.

Coverage is limited to services that would otherwise be covered if furnished by a Physician and that a CNM is legally authorized to perform under applicable State law.

d) Charges made by a Clinical Nurse Specialist (CNS) who meets all of the following requirements:

(i) who is a registered nurse currently licensed to practice in the State where he or she practices;

(ii) who is authorized to furnish the services of a CNS under applicable State law;

(iii) who has a master's degree in a defined clinical area of nursing from an accredited educational institution;

(iv) who is certified as a CNS by a recognized national certifying body that has established standards for CNSs;

(v) who acts within the scope of his or her license;

(vi) who is not a patient or the parent, spouse, sibling (by birth or marriage), or child of the patient; and

(vii) who acts in collaboration with a Physician.

Coverage is limited to services that would be considered physician's services if furnished by a Physician and that a CNS is legally authorized to perform under applicable State law.

e) Charges made by a certified/registered Surgical Assistant who meets all of the following requirements:

(i) who is legally licensed as a Surgical Assistant in the State in which services are furnished;

(ii) who acts within the scope of his or her license;

(iii) who is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient; and

(iv) acts under the supervision of a Surgeon. Coverage is limited to services that are of the type that would be considered surgical services if furnished by a Surgeon and that a Surgical Assistant is legally authorized to perform under applicable State law.

38. Diabetes counseling services when ordered by a Physician and performed by a provider licensed to perform such services under applicable law, including self-management training, education, equipment and supplies for the treatment of diabetes, and medical nutrition therapy (MNT), as provided below:

a) Up to three (3) visits following initial diagnosis of diabetes; and

b) Up to two (2) additional visits if a Physician has determined there has been significant change in a patient's symptoms.

39. Wigs or other cranial prosthesis for the loss of hair due to treatment of a malignancy (chemotherapy, radiation) or permanent hair loss from an Injury or Alopecia up to $500 per person per calendar year, subject to the annual deductible and 20% coinsurance. Written approval from a physician is required.

Hospice Benefit

The Hospice Benefit covers 100% of Reasonable and Customary Charges for the services outlined in the following chart up to a lifetime maximum shown in the *Schedule of Benefits* on page 5.

To be eligible for hospice benefits, the hospice care must be rendered as part of a Hospice Care Program by a licensed Hospice Care Agency. Before a covered individual enrolls in a Hospice Care Program, they should contact the Fund Office to verify that services will be covered under this benefit.

Schedule of Benefits for Hospice Services
Home Hospice Care – Allows patient to receive care in his or her own home.
Services and equipment covered at 100% include: • Physician services, • Physical, respiratory and occupational therapies, • Drugs, medications and medical supplies when provided under the Hospice Care Program through Hospice Care Agency, • Private duty nursing services by a Registered Nurse or Licensed Practical Nurse, if certified by a Physician, • Rental of Durable Medical Equipment (DME), as described in Appendix A on page 116, and • Oxygen and rental of related equipment.
Outpatient Hospice Care – Care that you receive in a licensed medical facility. After you receive treatment, you return to your home.
Services covered at 100% include: • Physician services, • Laboratory, X-ray and diagnostic testing, and • Ambulance service or alternative types of transportation.
Inpatient Hospice Care – Care received while you are an admitted patient in a Hospital or Hospice facility.
Services covered at 100% include: • Room and board for you which may include overnight accompaniment by family, • Nursing services, • All other related Hospital expenses, • Physician services, and • Ambulance service or alternative types of transportation.
Other Services – In addition to the services outlined above, certain other services for you and your family are also covered.
Services covered at 100% include: • Visits by a licensed social worker to evaluate the social, psychological and family problems related to the terminal illness. In addition, this professional will help develop a plan to assist in resolving these problems; • Emotional support services to help relieve stress, cope with the anticipated loss, complete unfinished family business and maintain the patient in the most appropriate environment;

Schedule of Benefits for Hospice Services
• Special incidental services for the patient, such as special dietary requirements, transportation between home and other sites of care; and • Bereavement counseling for the immediate family following the death of the Hospice patient. (Coverage is limited to six (6) visits.)

Preventive Services Benefit (Non-Medicare Eligible Retirees and Dependents)

Preventive Services, Wellness, Well-Child and Well-Baby Care Benefits

This Plan provides coverage for certain Preventive Services as required by the Patient Protection and Affordable Care Act of 2010 (ACA). Coverage is provided on an in-network basis, with no cost-sharing (for example, no deductibles, coinsurance, or copayments), and on an out-of-network basis, subject to cost-sharing, for the following services:

1. Services described in the United States Preventive Services Task Force (USPSTF) A and B recommendations,
2. Services described in the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC), and
3. Health Resources and Services Administration (HRSA) Guidelines including the American Academy of Pediatrics Bright Futures guidelines.

In-network preventive services that are identified by the Plan as part of the ACA guidelines will be covered with no cost-sharing by the Participant or Dependent. This means that the service will be covered at 100% of the Plan's Reasonable and Customary Charge, with no coinsurance, copay, or deductible. Out-of-network preventive services that are identified by the Plan as part of the ACA guidelines will be covered at 70% of the Reasonable and Customary Charge.

In some cases, federal guidelines are unclear about which preventive benefits must be covered under the ACA. In that case, the Trustees will determine whether a particular benefit is covered under this Preventive Services benefit.

Preventive Services Benefit Overview

1. *Physical Examination Benefit*: The Plan will cover the expense related to a routine physical examination (including routine OB/GYN exams) by a Physician. Routine physical examinations include baseline examinations, periodic examinations and those examinations performed due to a relevant family history.
2. Testing for asbestos/spirometry on Participants and Dependents will only be covered under the annual physical examination benefit charges for respiratory clearance or as required by federal law. The asbestos/spirometry tests must be performed in conjunction with an annual physical.
3. Physical examinations that are for purposes of meeting employment requirements will be covered by the Plan, but only if they are performed as part of the in-network annual physical examination. Such examinations will be subject to the benefit limitations listed on the Schedule of Benefits for wellness expenses and will be subject to the provisions governing the Plan's use and disclosure of your protected health information. These examinations must be performed in conjunction with an in-network annual physical examination.
4. Your Eligible Dependents through the age of 21 are entitled to coverage for well-child care benefits when provided by a network provider. Well-child care benefits include:
    a) Physical examinations; and
    b) Well-Child Required Immunizations, as recommended by the American Academy of Pediatrics.

5. The Plan also covers the immunization of girls and young women, ages 13 to 33, and boys ages 11 and 12, to prevent the human papillomavirus (HPV), a virus that can cause cervical cancer and other diseases.

6. Please note that Well-Child Required Immunization charges will be reimbursed when the service is rendered by a local Public Health Department but only after proof of payment is submitted to the Fund Office.

7. *Non-preventive Services are not covered without Cost-Sharing:* The plan will impose cost-sharing for treatment that is not a recommended preventive service, even if the treatment results from a recommended preventive service.

8. *Preventive Services for Dependents:* All covered Participants and Dependents are eligible to obtain, all required in-network (without cost sharing) and out-of-network (with cost-sharing) preventive services applicable to them (e.g., for their age group). This includes ACA-required pregnancy-related preventive services and well woman visits, which must be provided to Dependent Children (up to the end of the month that they turn age 26) where an attending provider determines that the services are age and developmentally appropriate.

Preventive Services under the Affordable Care Act ("ACA")

The Plan covers certain Preventive Services required by ACA. Coverage of these services is provided by PPO providers, with no cost-sharing (e.g., no deductibles, coinsurance, or copayments) and by non-PPO providers, with cost-sharing, for the following services:

1. Services described in the United States Preventive Services Task Force (USPSTF) A and B recommendations;

2. Services described in the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC);

3. Health Resources and Services Administration (HRSA) Guidelines including the American Academy of Pediatrics Bright Futures guidelines; and

4. With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.

Preventive services that are identified by the Plan as part of the ACA guidelines will be covered in network (with no cost-sharing) and out-of-network (with cost-sharing). This means that the service will be covered in-network at 100% of the Plan's Reasonable and Customary Charge, with no coinsurance, copay, or deductible, and out-of-network at 70% of the Plan's Reasonable and Customary Charge.

In some cases, federal guidelines are unclear about which preventive benefits must be covered under the ACA. In that case, the Trustees will determine whether a particular benefit is covered under this Preventive Services benefit.

Covered Preventive Services for Adults

1. Abdominal aortic aneurysm one-time screening for men ages 65-75 who have ever smoked.

2. Unhealthy alcohol use screening and counseling: screening and behavioral counseling interventions to reduce unhealthy alcohol use by adults ages 18 and older, including pregnant women, in primary care settings.

3. Low-dose aspirin to prevent cardiovascular disease and colorectal cancer when prescribed by a Health Care Provider, in adults ages 50 to 59 years who have a 10% or greater 10-year cardiovascular disease (CVD) risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years. A prescription must be submitted in accordance with plan rules.

4. Blood pressure screening for all adults age 18 and older. Blood pressure screening is not payable as a separate claim, as it is included in the payment for a Physician visit. The USPSTF recommends obtaining blood pressure measurements outside of the clinical setting for diagnostic confirmation before starting treatment.

5. Cholesterol screening (Lipid Disorders Screening) for adults aged 40-75.

6. Colorectal cancer screening using stool-based methods (such as fecal occult blood testing), sigmoidoscopy, or colonoscopy, in adults beginning at age 50 and continuing until age 75. The test methodology must be medically appropriate for the patient. The Plan will not impose cost sharing with respect to a polyp removal during a colonoscopy performed as a screening procedure. The plan will not impose cost sharing with respect to the following services when these services are provided in connection with a screening colonoscopy and the attending provider determines the service is medically appropriate: bowel preparation medications, anesthesia services, a pre-procedure specialist consultation, or a pathology exam on a polyp biopsy. The USPSTF recommends screening for colorectal cancer in adults aged 45 to 49.

7. Depression screening for adults.

8. Type 2 Diabetes in adults aged 40 to 70 who are overweight or obese, as part of cardiovascular risk assessment, with intensive behavioral counseling for those with abnormal blood glucose to promote a healthful diet and physical activity.

9. Healthy diet and physical activity behavioral counseling for adults with cardiovascular disease risk factors.

10. Screening for hepatitis B virus infection in adults at high risk for infection.

11. Screening for hepatitis C virus (HCV) infection in adults aged 18 to 79 years.

12. HIV screening for all adolescents and adults ages 15 to 65 and for younger and older individuals at increased risk.

13. Annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 20 pack/year smoking history and currently smoke or have quit within the past 15 years.

14. Obesity screening and intensive counseling and behavioral interventions to promote sustained weight loss for adults with a body mass index of 30 kg/m2 or higher.

15. Sexually Transmitted Infection (STI) behavioral counseling for adults at higher risk.

16. Syphilis screening for all adults at increased risk of infection.

17. Tobacco Use screening for all adults and cessation interventions for tobacco users.

18. Counseling for young adults to age 24 who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.

19. Exercise or physical therapy to prevent falls in community-dwelling adults age 65 years or older who are at increased risk for falls.

20. Low to moderate dose statin for the prevention of cardiovascular disease (CVD) events and

mortality in adults ages 40 to 75 years with one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking), and a calculated 10-year risk of a cardiovascular event of 10% or greater, when identified as meeting these factors by their treating physician.

21. Screening for latent tuberculosis infection in populations at increased risk.

22. Preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition.

Covered Preventive Services for Women, Including Pregnant Women

1. Well woman office visits for women beginning in adolescence and continuing across the lifespan, for the delivery of required preventive services.

2. Bacteriuria urinary tract or other infection screening for pregnant women. Screening for asymptomatic bacteriuria with urine culture for pregnant women is payable at 12 to 16 weeks' gestation or at the first prenatal visit, if later.

3. BRCA counseling about genetic testing for women at higher risk. Women whose family history is associated with an increased risk for deleterious mutations in BRCA 1 or BRCA 2 genes will receive referral for counseling. The Plan will cover BRCA 1 or 2 genetic tests without cost sharing, if appropriate as determined by the woman's Health Care Provider, including for a woman who has previously been diagnosed with cancer, as long as she is not currently symptomatic or receiving active treatment for breast, ovarian, tubal, or peritoneal cancer.

4. Breast cancer screening mammography for women with or without clinical breast examination and with or without diagnosis, every 1 to 2 years for women aged 40 and older.

5. Breast Cancer Chemoprevention counseling for women at higher risk. The Plan will pay for counseling by Physicians with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention, to discuss the risks and benefits of chemoprevention. The Plan will also pay for risk-reducing medications (such as tamoxifen or raloxifene) for women at increased risk for breast cancer and at low risk for adverse medication effects.

6. Comprehensive lactation support and counseling by a trained provider during pregnancy and for the duration of breastfeeding, and costs for renting breastfeeding equipment. The Plan may pay for purchase of lactation equipment instead of rental, if deemed appropriate by the Fund Administrator.

7. Cervical Cancer screening for women ages 21 to 29 with Pap smear every three years; for women ages 30-65, screening with Pap smear alone every three years, or screening with Pap smear and human papillomavirus testing every five years.

8. Chlamydia Infection screening for all sexually active non-pregnant young women aged 24 and younger, and for older non-pregnant women who are at increased risk, as part of a well woman visit. For all pregnant women aged 24 and younger, and for older pregnant women at increased risk, Chlamydia infection screening is covered as part of the prenatal visit.

9. FDA-approved contraceptives methods, sterilization procedures, and patient education and counseling for women of reproductive capacity. FDA-approved contraceptive methods include barrier methods, hormonal methods, and implanted devices, as well as patient education and counseling, as prescribed by a Health Care Provider. The Plan may cover a generic drug without cost sharing and charge cost sharing for an equivalent branded drug. The Plan will accommodate any individual for whom the generic would be medically inappropriate, as determined by the individual's Health Care Provider. Services related to follow-up and management of side effects, counseling for continued adherence, and device removal are also covered without cost sharing.

10. Folic Acid supplements for women who are planning or capable of pregnancy, containing 0.4 to 0.8 mg of folic acid. Over-the-counter supplements are covered only if the woman obtains a prescription.

11. Gonorrhea screening for all sexually active women age 24 and younger and in older women who are at increased risk for infection, provided as part of a well woman visit. The Plan will pay for the most cost-effective test methodology only.

12. Counseling for sexually transmitted infections, once per year as part of a well woman visit.

13. Counseling and screening for HIV, once per year as part of a well woman visit, and for pregnant women, including those who present in labor who are untested and whose HIV status is not known.

14. Hepatitis B screening for pregnant women at their first prenatal visit.

15. Osteoporosis screening for women. Women aged 65 and older will be eligible for routine screening for osteoporosis. Younger women will be eligible for screening if their risk of fracture is equal to or greater than that of a 65-year old woman. The Plan will pay for the most cost-effective test methodology only.

16. Rh Incompatibility screening for all pregnant women during their first visit for pregnancy related care, and follow-up testing for all unsensitized Rh (D) negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D) negative.

17. Screening for diabetes after pregnancy in women with history of gestational diabetes who are not currently pregnant and who have not previously been diagnosed with type 2 diabetes.

18. Screening for gestational diabetes in asymptomatic pregnant women between 24 and 28 weeks' gestation and at the first prenatal visit for pregnant women identified to be at risk for diabetes.

19. Tobacco Use screening and interventions for all women, as part of a well woman visit, and expanded counseling for pregnant tobacco users.

20. Syphilis screening for all pregnant women or other women at increased risk, as part of a well woman visit.

21. Screening and counseling for interpersonal and domestic violence, as part of a well woman visit.

22. Low-dose aspirin after 12 weeks of gestation for women who are at high risk for preeclampsia. A prescription must be submitted in accordance with Plan rules.

23. Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy. Blood pressure screening is not payable as a separate claim, as it is included in the payment for a physician visit.

24. Depression screening for pregnant and postpartum women.

25. Screening for urinary incontinence annually.

26. Screening for anxiety.

27. Behavioral counseling interventions aimed to promote healthy weight gain and prevent excess gestational weight gain during pregnancy.

Covered Preventive Services for Children

1. Well baby and well child visits from age newborn through 21 years as recommended for pediatric preventive health care by "Bright Futures/American Academy of Pediatrics." Visits will include the following age-appropriate screenings and assessments:

a) Alcohol and Drug Use assessments for adolescents.

b) Autism screening for children at 18 and 24 months.

c) Behavioral assessments for children of all ages.

d) Blood pressure screening.

e) Cervical Dysplasia screening at age 21.

f) Depression screening for adolescents ages 12 and older.

g) Developmental screening for children under age 3, and surveillance throughout childhood.

h) Dyslipidemia screening for children at higher risk of lipid disorders.

i) Hearing screening.

j) Height, Weight and Body Mass Index measurements for children.

k) Hematocrit or hemoglobin screening for children.

l) Critical congenital heart defect screening in newborns.

m) Lead screening for children at risk of exposure.

n) Medical history.

o) Oral Health risk assessment for young children from 6 months to 6 years.

p) Sexually Transmitted Infection (STI) prevention counseling and screening for sexually active adolescents.

q) Tuberculin testing for children at higher risk of tuberculosis.

r) Vision screening at least once in all children 3 to 5 years to detect amblyopia or its risk factors.

s) Counseling for children, adolescents, and young adults ages 6 months to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce their risk for skin cancer.

t) Interventions, including education or brief counseling, to prevent initiation of tobacco use (including e-cigarettes) in in school-aged children and adolescents.

u) Screening for hepatitis B virus infection in adolescents at high risk for infection.

v) Application of fluoride varnish to the primary teeth of all infants and children through to age five starting at the age of primary tooth eruption, in primary care practices.

w) Syphilis screening for adolescents who are at increased risk for infection.

x) For adolescents, screening and counseling for interpersonal and domestic violence.

y) For adolescent women, screening for anxiety.

2. Newborn screening tests recommended by the Advisory Committee on Heritable Disorders in Newborns and Children (such as hypothyroidism screening for newborns and sickle cell screening for newborns).

3. Prophylactic ocular topical medication for all newborns for the prevention of gonorrhea.

4. Oral fluoride supplementation at recommended doses (based on local water supplies) to preschool children older than 6 months of age whose primary water source is deficient in fluoride. Over-the-

counter supplements are covered only with a prescription.

5. Obesity screening for children aged 6 years and older, and counseling or referral to comprehensive, intensive behavioral interventions to promote improvement in weight status.
6. HIV screening for adolescents ages 15 and older and for younger adolescents at increased risk of infection.
7. Preexposure prophylaxis (PrEP) with effective antiretroviral therapy to adolescents who are at high risk of HIV acquisition.

Immunizations

Routine adult immunizations are covered for Participants and Dependents who meet the age and gender requirements and who meet the Centers for Disease Control and Prevention (CDC) medical criteria for recommendation.

1. Immunization vaccines for adults – doses, recommended ages, and recommended populations must be satisfied:
    a) Diphtheria/tetanus/pertussis (DtaP)
    b) Measles/mumps/rubella (MMR)
    c) Influenza
    d) Human papillomavirus (HPV)
    e) Pneumococcal (polysaccharide)
    f) Zoster (Shingles)
    g) Hepatitis A
    h) Hepatitis B
    i) Meningococcal
    j) Varicella
    k) COVID-19
2. Immunization vaccines for children from birth to age 18—doses, recommended ages, and recommended populations must be satisfied:
    a) Hepatitis B
    b) Rotavirus
    c) Diphtheria, Tetanus, Pertussis (DtaP)
    d) Haemophilus influenza type b
    e) Pneumococcal
    f) Inactivated Poliovirus
    g) Influenza
    h) Measles, Mumps, Rubella (MMR)
    i) Varicella
    j) Hepatitis A

k) Meningococcal

l) Human Papillomavirus (HPV)

m) COVID-19

Office Visit Coverage

Preventive Services are paid for based on the Plan's payment schedules for the individual services. However, there may be limited situations in which an office visit is payable under the Preventive Services benefit. The following conditions apply to payment for in-network or out-of-network office visits under the Preventive Services benefit.

1. If a preventive item or service is billed separately from an office visit that is not part of a physical exam, then the Plan will impose cost sharing with respect to the office visit.
2. If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is the delivery of such preventive item or service, then the Plan will pay 100 percent for the office visit.
3. If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is not the delivery of such preventive item or service, then the Plan will impose cost sharing with respect to the office visit.

For example, if a person has a cholesterol screening test during an office visit, and the doctor bills for the office visit and separately for the lab work associated with the cholesterol screening test, the Plan will charge a copayment for the office visit that is not a physical exam, but not for the lab work. In this case, the lab work will be paid at 100%. If a person sees a doctor to discuss recurring abdominal pain and has a blood pressure screening during that visit, the Plan will charge a copayment for the office visit because the blood pressure check was not the primary purpose of the office visit.

Well child annual physical exams recommended in the Bright Futures Recommendations are treated as Preventive Services and paid at 100% if provided in-network and at 70% if provided out-of-network. Well woman visits are also treated as Preventive Services and paid at 100% if provided in-network and at 70% if provided out-of-network.

Preventive Services Coverage Limitations and Exclusions

1. Preventive Services are covered when performed for preventive screening reasons and billed under the appropriate preventive services codes. Services covered for diagnostic reasons are covered under the applicable Plan benefit, not the Preventive Services benefit. A service is covered for diagnostic reasons if the Participant or Dependent had symptoms requiring further diagnosis or abnormalities found on previous preventive or diagnostic studies that required additional examinations, screenings, tests, treatment, or other services.
2. Services covered under the Preventive Services Benefit are not also payable under other portions of the Plan.
3. The Plan will use reasonable medical management techniques to control costs of the Preventive Services benefit. The Plan will establish treatment, setting, frequency, and medical management standards for specific Preventive Services, which must be satisfied in order to obtain payment under the Preventive Services benefit.
4. Immunizations are not covered, even if recommended by the CDC, if the recommendation is based

on the fact that some other risk factor is present (e.g., on the basis of occupational, lifestyle, or other indications). Travel immunizations, e.g., typhoid, yellow fever, cholera, plague, and Japanese encephalitis virus, are not covered.

5. Examinations, screenings, tests, items or services are not covered when they are investigational or experimental (except for Approved Clinical Trials, as discussed below and required under the Affordable Care Act), as determined by the Plan.

6. Examinations, screenings, tests, items, or services are not covered when they are provided for the following purposes:

   a) When required for travel, insurance, marriage, adoption, or other non-medical purposes;

   b) When related to judicial or administrative proceedings;

   c) When related to medical research or trials; or

   d) When required to maintain employment or a license of any kind (except for Department of Transportation exams and required tests).

7. Drugs, medicines, vitamins, and/or supplements, whether available through a prescription or over-the-counter, are not covered under the Preventive Services benefit, except as stated above.

8. Services related to a man's reproductive capacity, such as vasectomies and condoms.

Approved Clinical Trials

Covered Expenses include:

1. Charges incurred due to participation in either a Phase I, II, III, or IV Approved Clinical Trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, provided the charges are those that are:

   a) Ancillary to participation in the Approved Clinical Trial and would otherwise be covered under this Plan if the individual were not participating in the Approved Clinical Trial; and

   b) Not attributable to any device, item, service, or drug that is being studied as part of the Approved Clinical Trial or is directly supplied, provided, or dispensed by the provider of the Approved Clinical Trial.

2. A Participant or Dependent is eligible for payment of charges related to participation in an Approved Clinical Trial if he or she:

   a) Satisfies the protocol prescribed by the Approved Clinical Trial provider; and

   b) Either:

      i) The individual's network participating provider determines that the individual's participation in the Approved Clinical Trial would be medically appropriate; or

      ii) The individual provides the Plan with medical and scientific information establishing that participation in the Approved Clinical Trial would be medically appropriate.

For the purposes of this provision, an Approved Clinical Trial means a Phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The Approved Clinical Trial's study or investigation must be (1) approved or funded by one or more of: (a) the National Institutes of Health (NIH), (b) the Centers for Disease Control and Prevention

(CDC), (c) the Agency for Health Care Research and Quality (AHCRQ), (d) the Centers for Medicare and Medicaid Services (CMS), (e) a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD), or the Department of Veterans Affairs (VA); (f) a qualified non-governmental research entity identified by NIH guidelines for grants; or (g) the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review; (2) a study or trial conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements.

Excluded Expenses include:

1. Expenses incurred due to participation in an Approved Clinical Trial that are: (1) the investigational items, devices, services, or drugs being studied as part of the Approved Clinical Trial; (2) items, devices, services, and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services, or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.
2. Expenses incurred at a non-network provider if a network participating provider will accept the patient in an Approved Clinical Trial.

Wellness Expense Benefit (Medicare Eligible Retirees and Spouse Only)

The Fund will pay wellness benefits for Medicare Eligible Retirees and their spouse. These benefits include:

- Physical examinations,
- Blood tests,
- Pap smears,
- X-rays,
- Mammograms,
- EKGs
- Smoking cessation programs, and
- Other routine services and covered supplies that contribute to maintaining your wellness, if approved in advance by the Fund Office, and are not covered elsewhere under the Plan. A request for such pre-approval constitutes a pre-service claim. See the *Pre-service Claims* section on page 78.

The Plan covers a variety of wellness expenses for you and your spouse.

You do not need to pay a deductible or copayment for these benefits, and you may use either PPO or non-PPO healthcare Providers.

Wellness benefits are provided only for you and your spouse and are not provided for your Dependent Children.

Please note that wellness benefits will only be paid when your Physician uses a diagnosis code that qualifies for reimbursement under the Fund. For more information, please contact the Fund Office.

Non-Medicare Eligible Retirees, their spouses and Dependents are eligible for preventive care benefits under the Comprehensive Major Medical Benefit.

Dental Benefits (Retirees and Dependents)

The Fund provides you and your Dependents with coverage for dental services as outlined in the *Schedule of Benefits* on pages 6 and 7. You must satisfy your calendar year deductible before the Fund pays its percentage of your covered dental benefits.

Delta Preferred Option USA (Point-of-Service) Program

You can go to any licensed Dentist, but you could increase your benefits and lower your out-of-pocket costs by going to a Dentist who participates with Delta Dental. There are two levels of savings within this program. The highest level of cost savings occurs if you go to a Delta Preferred Option (DPO) Dentist. Your savings would be the result of lower out-of-pocket costs under your copays.

If you do not go to a DPO Dentist, savings are still possible if the Dentist participates in another Delta Dental program called *Delta Premier*. This second level of coverage may reduce your costs in comparison to a Dentist that does not participate with Delta Dental, but you might have to pay more than if you chose a DPO Dentist.

Dentists who participate in the DPO USA (Point-of-Service) program at either level have agreed to accept payment based on a predetermined schedule. If the Dentist's fee is higher than the amount in the Delta Dental fee schedule, he or she cannot charge you the difference. This means you will pay only your copayment and deductible, if any, for covered services when you go to a Delta Dental participating Dentist. Participating Dentists will also complete and file claims for you.

There are more than 108,000 Delta Premier Dentists. To find the names of participating Dentists near you, call the Fund Office or visit www.deltadentalil.com. Please note that you remain free to visit any Dentist you choose regardless of DPO or Delta Premier membership.

Important. If you go to a Delta Dental participating Dentist, the Dentist will submit the claim form and you will only be responsible for any deductibles and copayments. If you go to a non-participating Dentist, you may be required to pay the Dentist his or her fees at the time of service and then file a claim with Delta Dental for reimbursement under the Dental Plan.

Predetermination of Benefits

In order to help you avoid any large, unexpected dental bills, if your Dentist expects that the course of treatment recommended will exceed $300, you should ask your Dentist to submit to Delta Dental of Illinois the treatment plan that describes each procedure necessary to fully complete treatment before starting any dental work. Delta Dental of Illinois will review the information to determine how much the Fund will pay.

Be prepared: By requesting a Predetermination of Benefits, you can find out from Delta Dental how much the Plan will cover for your dental procedure and how much you will be required to pay.

This Predetermination of Benefits is a convenience to let you know in advance what portion of the cost of your dental treatment will be your responsibility. Delta Dental of Illinois will respond directly to your Dentist with its decision as to whether or not the dental treatment will be covered and how much will be paid. The Predetermination of Benefits is also available if your Dentist is not participating in the Delta Dental Plan.

This Predetermination of Dental Benefits is not a guarantee of coverage. It is intended to let you know in advance what portion of the cost of your dental treatment will be your responsibility.

Covered Dental Services

Class I Benefits – Preventive Services
• **Diagnostic and Preventive Services**: Services and procedures to evaluate existing conditions and/or to prevent dental abnormalities or disease. These services include examinations, prophylaxes, and fluoride treatments. • **Emergency Palliative Treatment**: Emergency treatment to temporarily relieve pain. • **Radiographs**: X-rays as required for routine care or as necessary for the diagnosis of a specific condition. • **Recement Crowns**.
Class II Benefits – Basic Services
• **Endodontic Services**: The treatment of teeth with diseased or damaged nerves (for example, root canals). Excludes apicoectomy. • **Minor Restorative Services**: Minor services to rebuild and repair natural tooth structure when damaged by disease or Injury. Minor restorative services include amalgam (silver) and resin (white) fillings. • **Emergency and Specialty Exams**.
Class III Benefits – Major Services
• **Oral Surgery Services**: Extractions and dental surgery, including preoperative and postoperative care. • **Periodontic Services**: The treatment of diseases of the gums and supporting structures of the teeth. This includes periodontal maintenance following active therapy (periodontal prophylaxes). Actisite is a covered benefit. • **Relines and Repairs**: Relines and repairs to crowns, bridges, partial dentures, and complete dentures. • **Major Restorative Services**: Services to rebuild and repair natural tooth structure when damaged by disease or Injury, such as crowns, used when teeth cannot be restored with another filling material. • **Prosthodontic Services**: Services and appliances that replace missing natural teeth (such as bridges, partial dentures, and complete dentures). • **Veneers** – **Labial Veneers** – (cosmetic bonding). • **Apicoectomy** – **Periradicular Surgery**. • **Dental Anesthesia**: Dental anesthesia is payable at 50%, subject to the deductible and calendar year maximum. General anesthesia/IV sedation is a covered charge only if there is demonstrated medical need, including the following: o Toxicity to local anesthetic, o Severe disability, spastic or severe behavioral problems, o Prolonged or severe surgical procedure (includes removal of impacted tooth-soft tissue, removal of impacted tooth – partial bony, removal impacted tooth – completely bony impacted, surgical removal of residual tooth roots (cutting procedure), o Extractions in two or more quadrants, o Acute infection around the injection site, o Failure of local anesthesia to control pain, or o Subject is under four years of age.

Dental Service Limitations

Covered dental services are limited in certain cases. All charges for the following dental services will be your responsibility. All time limitations are measured from the last date of service in any Delta Dental plan record or, at the request of your group, any dental plan record:

1. Four (4) bitewing X-rays are payable once in any calendar year. Full-mouth X-rays (which include bitewing X-rays) are payable once in any three (3) year period. A panographic X-ray (including bitewings) is considered a full-mouth X-ray. Bitewing X-rays, full-mouth X-rays and Periapical X-rays are covered without limitation for Dependent Children up to age 19.
2. Prophylaxes and oral exams are payable twice in any calendar year. Two (2) additional periodontal prophylaxes are payable per calendar year for individuals with a documented history of periodontal disease. Preventive fluoride treatments are covered without limitation for Dependent Children up to age 19. Oral exams, including specialty and emergency exams, are covered without limitation for Dependent Children up to age 19.
3. A space maintainer is a covered benefit for patients up to the age of 19.
4. Cast restorations (including jackets, crowns, inlays and onlays) and associated procedures (such as core build-ups and post substructures) on the same tooth are payable once in any five (5) year period.
5. A crown, inlay, or onlay is a covered benefit only for extensive loss of tooth structure due to caries and/or fracture.
6. An individual crown over an implant is payable at the prosthodontic benefit level.
7. Porcelain, porcelain substrate, and cast restorations are not payable for Children younger than 12 years of age.
8. A stayplate is a covered benefit only for the replacement of permanent anterior teeth during the healing period or for missing anterior permanent teeth for Dependent Children 16 years or younger.
9. Prosthodontic (Class III) benefit limitations:
    a) One (1) complete upper and one (1) complete lower denture are benefits once in any five (5) year period for any individual.
    b) A removable partial denture or fixed bridge for any individual can be covered once in any five (5) year period unless the loss of additional teeth requires the construction of a new appliance. Fixed bridges are covered only for Participants 16 years or older.
    c) A reline or the complete replacement of denture base material is limited to once in any three (3) year period per appliance.
    d) A soft reline is limited to once in any three (3) year period.
    e) Root-planing benefits are payable once per year.
10. The Plan's obligation for payment of benefits ends on the last day of the month in which coverage is terminated. However, the Plan will make payment for covered services provided on or before the last day of the month in which coverage is terminated, unless otherwise specified.
11. When services in progress are interrupted and completed later by another Dentist, Delta Dental will review the claim to determine the amount of payment, if any, to each Dentist.
12. Care terminated due to the death of a Participant will be paid to the limit of the Fund maximum for the services completed or in progress.

13. Optional treatment: If the Participant chooses a more expensive service than is customarily provided or for which the Plan or Delta Dental does not determine a valid dental need is shown, the Plan or Delta Dental can make an allowance based on the fee for the customarily provided service.

    For example, if the Participant chooses an overdenture, the Fund will pay only the applicable amount that it would have paid for a conventional denture.

14. Maximum Payment: The maximum benefit payable in any one calendar year will be limited to the amount specified in the *Schedule of Benefits* on pages 6 and 7.

15. The Plan and Delta Dental will not be obligated to pay for any services to which the deductible applies until the Plan deductible amount is met.

16. Processing policies, such as periodic limitations on certain services, may limit treatment.

Services Not Paid by the Plan

No payment will be made by the Plan for the following services. A participating Dentist cannot charge you or your eligible Dependent for these services. All charges from non-participating Dentists for the following services will be your responsibility:

1. Amalgam and resin restorations are payable once within a twenty-four (24) month period, regardless of the number or combination of restorations placed on a surface.

2. Cores and other substructures are covered benefits only when needed to retain a crown on a tooth with excessive breakdown due to caries and fractures.

3. Recementation of a crown, onlay, inlay, space maintainer, or bridge within six (6) months of the seating date or within twelve (12) months of payment for a recementation.

4. Retention pins are benefits once in a twenty-four (24) month period. Only one (1) substructure per tooth is a covered benefit.

5. Benefits for periodontal surgery, including subgingival curettage, is payable once in any three (3) year period.

6. A complete occlusal adjustment is a covered benefit once in a five (5) year period. The fee for a complete occlusal adjustment includes all adjustments that are necessary for a five (5) year period. A limited occlusal adjustment is not a covered benefit more than three (3) times in a five (5) year period. The fee for a limited occlusal adjustment includes all adjustments that are necessary for a six (6) month period.

7. Tissue conditioning is not a covered benefit more than twice per arch in thirty-six (36) months.

8. The allowance for a denture repair (including reline or rebase) will not exceed one-half the fee for a new denture.

9. More than one (1) root planing per year.

Dental Exclusions

In addition to the General Exclusions and Limitations listed beginning on page 71, the Fund does not cover any loss under the Dental Benefits caused by, incurred for or resulting from the following excluded charges. All charges for the following services will be your responsibility, although your payment obligation may be satisfied by insurance or some other arrangement for which you are eligible:

1. Services, as determined by the Fund, for correction of congenital or developmental malformations, cosmetic surgery, or dentistry for cosmetic aesthetic reasons including repair to facings posterior to the second bicuspid position.
2. Prescription drugs (except intramuscular injectable antibiotics), premedications, medicaments/solutions, and relative analgesia. Medicines or drugs that can be obtained without a Dentist's prescription.
3. General anesthesia and/or intravenous sedation for restorative dentistry (or for surgical procedures) except as provided under Class III Benefits on page 56.
4. Acupuncture, acupressure or hypnosis.
5. Charges for hospitalization, laboratory tests and histopathological examinations.
6. Treatment performed by anyone other than a Dentist, except for services performed by a licensed Dental Hygienist under the scope of his or her license.
7. Services that are covered under the Major Medical or Prescription Drug Benefits.
8. Fluoride rinses, self-applied fluorides or desensitizing medicaments.
9. Preventive control programs (including oral hygiene instructions, caries susceptibility tests, dietary control, tobacco counseling, home-care medicaments, nutritional guidance, etc.).
10. Sealants.
11. A space maintainer for maintaining space due to the premature loss of the anterior primary teeth.
12. Lost, missing, or stolen appliances of any type and replacement or repair of orthodontic appliances or space maintainers.
13. A prefabricated crown used as a final restoration on a permanent tooth.
14. Appliances, surgical procedures, and restorations for increasing vertical dimension; altering, restoring, or maintaining occlusion; replacing tooth structure loss resulting from attrition, abrasion, or erosion; or implantology techniques or periodontal splinting.
15. A substructure to a single/abutment crown over an implant.
16. A paste-type root canal filling on a permanent tooth.
17. Occlusal guards.
18. Chemical curettage.
19. Services associated with overdentures.
20. Acusil, flexiplast or similar partial denture.
21. A metal base on a removable prosthesis.
22. The replacement of teeth beyond the normal complement of teeth.
23. Personalization/characterization of any service or appliance.

24. Temporary appliances.

25. Precision attachments.

26. Implants and implant-related services.

27. Appliances, restorations or services for the diagnosis or treatment of disturbances of the temporomandibular joint dysfunction (TMJ or TMD).

28. Myofunctional therapy.

29. Mounted case analysis.

30. The replacement or alteration of full or partial dentures or fixed bridgework, unless the charge is required due to one of the following events and if the replacement or alteration is completed within twelve (12) months after the event:

    a) An Injury requiring surgery; or

    b) Oral surgery treatment involving the repositioning of muscle attachments or the removal of a tumor, cyst, torus or redundant tissue; or

    c) Replacement of a full denture, unless required as the result of structural change within the mouth and unless made more than five (5) years after the installation of the denture.

31. Orthodontic treatment for you and your spouse or Dependent Child.

32. Charges for failure to keep a scheduled visit with the Dentist.

33. Services, as determined by Delta Dental, for which no valid dental need can be demonstrated, that are specialized techniques, or that are experimental or investigational in nature as determined by the standards of generally accepted dental practice.

34. Those benefits excluded by the policies and procedures of Delta Dental, including the processing policies.

35. Services or supplies for which no charge is made, for which you are not legally obligated to pay or for which no charge would be made in the absence of Delta Dental coverage.

36. Services or supplies received as a result of dental disease, defect or Injury due to an act of war, declared or undeclared.

37. Services that are not within the classes of benefits that have been selected and that are not in the contract.

38. Replacement, repair, relines or adjustments of occlusal guards.

Dental Charges Not Paid by the Fund or Delta Dental

No payment will be made by the Plan or Delta Dental for the following services. A participating Dentist cannot charge you or your Eligible Dependent for these services. All charges from non-participating Dentists for the following services will be your responsibility:

1. The fee for a consultation that is part of the fee for the examination and/or diagnostic procedure(s).

2. Acid etching, cement bases, cavity liners, and a base or temporary filling.

3. Infection control.

4. Gingivectomy as an aid to the placement of a restoration.

5. The correction of occlusion, when performed with prosthetics and restorations involving occlusal surfaces.
6. Diagnostic casts. They are considered to be a part of the fee for restorative or prosthodontic procedures.
7. Palliative treatment, when any other service is provided on the same date, except X-rays and tests necessary to diagnose the emergency condition.
8. Postoperative radiographs, when done following any completed service or procedure.
9. Periodontal charting, when done on the same day as an oral examination. An examination, when done on the same day as a periodontal prophylaxis.
10. Pins and/or a preformed post, when done with a core for a crown, onlay, or inlay.
11. A pulp cap, when done with a sedative filling or any other restoration. A sedative or temporary filling, when done with the opening and drainage of a tooth or another endodontic procedure. The opening and drainage of a tooth or palliative treatment, when done on the same day a root canal is initiated.
12. A therapeutic apical closure on a permanent tooth, except on a tooth where the root is not fully formed.
13. Retreatment of a root canal within twelve (12) months of the original root canal treatment.
14. A prophylaxis, when done on the same day as root planing. Root planing, when done on the same day as subgingival curettage.
15. An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.
16. Reline, rebase, or any adjustment or repair within six (6) months of the delivery of a partial denture.
17. Tissue conditioning, when performed on the same day as the delivery of a denture or the reline or rebase of a denture.
18. The completion of claim forms.
19. Temporary crowns.
20. Local Anesthesia, except as provided under Class III Benefits on page 56.

Extension of Dental Benefits

Dental benefits may be payable for unfinished dental work performed within sixty (60) days after termination of coverage as if the expenses were incurred while covered if coverage terminates:

- For any reason other than termination of the Fund, and
- Before the completion of a course of dental treatment that began before such termination.

In those cases, Delta Dental evaluates those services in progress to determine what portion may be paid by Delta Dental. Any balance of the total fee not paid by Delta Dental is your responsibility.

Opt-Out of Dental Benefits

If you wish, you may elect to cease coverage for Dental Benefits under the Plan for yourself or your Eligible Dependents at any time during the Plan Year by providing written notice to the Fund Office of your intention to cease Dental coverage. Cessation of Dental coverage will be effective as of the first day of the following month after the Fund Office receives such notice from you.

If you previously elected to cease coverage for Dental Benefits under the Plan, you may reinstate coverage by providing written notice to the Fund Office. Reinstatement of Dental coverage will be effective as of the first day of the Plan Year following the date the Fund Office receives such written notice from you.

Optical Benefits (Retirees and Dependents)

To help you with vision care, the Fund pays Optical Benefits up to the maximum amount shown in the *Schedule of Benefits* on pages 6 and 7 during a **consecutive two (2) year period** for the following:

- Professional examination by an ophthalmologist (MD) or optometrist;
- Lenses prescribed by an ophthalmologist (MD) or a licensed optometrist, including prescription sunglasses, transitional lenses, tinted lenses, contact lenses and safety glasses; and
- Frames purchased in conjunction with lenses newly prescribed by an ophthalmologist (MD) or a licensed optometrist.

See the applicable *Schedule of Benefits* for the amount of optical benefits provided by the Plan.

Professional examination for pediatric preventive care and screenings by an ophthalmologist (MD) or optometrist for children up to age 19 is covered, without limitations.

You are not required to pay a deductible or copayment before the Fund pays optical/vision benefits.

Call EyeMed Vision Care at 1-866-723-0514 for help finding a network provider or access the web site at www.eyemedvisioncare.com

The Trustees have contracted with an optical PPO, EyeMed Vision Care, that provides first-dollar benefits up to the maximum in the applicable Schedule of Benefits. Because EyeMed provides discounts for eye examinations, lenses and frames, your benefit amount will go further. You do not have to submit a vision claim form, but you will be required to pay the EyeMed Provider for any cost over your maximum when you pick up your glasses or contact lenses. The benefits provided by EyeMed Vision Care are summarized as follows, subject to all terms and conditions of the EyeMed Vision Care program which are subject to change. Additional discounts and exclusions apply. Contact EyeMed Vision Care at 1-866-723- 0514 for help finding a network provider or access to the website at www.eyemedvisioncare.com.

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam with Dilation as Necessary	$0 Copay	Up to $50
Frames, Lens & Options Package (Any frame, lens and lens options available at provider location.)	$425 Allowance for frame, lens and lens options; 20% off balance over $425	Up to $250
Contact Lenses – Declining Balance* Conventional Disposable Medically Necessary	 $0 Copay, $255 allowance; 15% off balance over $255 $0 Copay, $255 allowance; plus balance over $255 $0 Copay, Paid-in-Full	 Up to $250 Up to $250 Up to $250
Laser Vision Correction Lasik or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	N/A

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Additional Pairs Benefit:	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Frequency:		
Examination	Members < 19 Years of Age (Once Every 12 Months) Members >+= 19 Years of Age (Once Every 24 Months)	
Frame & Lenses or Contact Lenses	Once every 24 months – Any age	

* Any remaining balance may be used within the same Benefit Frequency. Where the Insured Person previously utilized an In-Network Provider, the remaining balance must be used with the same or any other In-Network Provider. Where the Insured Person previously utilized an Out-of-Network Provider, the remaining balance must be used with the same or any other Out-of-Network Provider.

If you use an Out-of-Network Provider, you are required to pay the entire cost up front to the Provider. You must submit a vision claim form to EyeMed. EyeMed will process the claim and remit payment, up to the applicable maximum, directly to you.

In addition to the exclusions listed in the *General Exclusions and Limitations* section on page 71, the Fund will not pay optical benefits for routine yearly examinations required by an employer in connection with your occupation.

Opt-Out of Optical Benefits

If you wish, you may elect to cease coverage for Optical Benefits under the Plan for yourself or your Eligible Dependents at any time during the Plan Year by providing written notice to the Fund Office of your intention to cease coverage of Optical Benefits. Cessation of Optical Benefit coverage will be effective as of the first day of the following month after the Fund Office receives such notice from you.

If you previously elected to cease coverage for Optical Benefits under the Plan, you may reinstate coverage by providing written notice to the Fund Office. Reinstatement of Optical Benefit coverage will be effective as of the first day of the Plan Year following the date the Fund Office receives such written notice from you.

Hearing Aid Benefit (Retirees and Dependents)

The Fund provides coverage for you and your Dependents for hearing aid devices. Maximums are shown in the applicable *Schedule of Benefits* on pages 6 and 8. Payment will be made for a hearing aid device only if:

- An examination indicates a need for a hearing aid, and
- The examination and the hearing aid are both furnished by a Doctor or by an Audiologist who is certified by the American Speech-Language Hearing Association.

The Fund covers up to $150 of the cost of a hearing examination for you and your Dependents. The Fund provides this benefit once per calendar year.

You are not required to pay a deductible or copayment before the Fund pays hearing aid benefits.

The Trustees have identified a hearing aid PPO that Participants are free to contact. The PPO provides discounts on hearing aid devices and related services. The name of the PPO is Amplifon Hearing Health Care.

Call Amplifon Hearing Health Care at 1-888-601-8598 for help finding a network Provider.

To contact Amplifon Hearing Health Care for the name of a participating Audiologist or Physician in your area, call its toll-free number at 1-888-601-8598. Please note that you remain free to visit any Audiologist or Physician you choose regardless of whether they are part of the Amplifon Hearing Health Care network.

Prescription Drug Benefits (Retirees and Dependents)

The Plan provides Prescription Drug Benefits for you and your Dependents for drugs and/or medicines that are prescribed by your Physician. The Plan will pay the cost of the prescription, less any copayment after you have paid your calendar year deductible. The copayments and deductible are listed in the applicable *Schedule of Benefits* on pages 6 and 7.

The prescription drug program provides coverage for both acute medications (immediate treatment) and maintenance medications (long-term treatment).

The Plan covers FDA-approved contraceptives methods, sterilization procedures, and patient education and counseling for women of reproductive capacity with no cost sharing. FDA-approved contraceptive methods include barrier methods, hormonal methods, and implanted devices, as well as patient education and counseling, as prescribed by a Health Care Provider. FDA-approved contraceptives will be covered subject to the Plan design shown in the *Schedule of Benefits* on pages 4 and 7. The Plan will accommodate any individual for whom the generic would be medically inappropriate, as determined by the individual's Health Care Provider. Services related to follow-up and management of side effects, counseling for continued adherence, and device removal are also covered without cost sharing.

Retail Pharmacy Network (30 and 90 day supplies)

Acute medications are usually prescribed to treat acute conditions of a short-term or temporary nature such as an infection or the flu. They are limited to a thirty-four (34) day supply.

To fill this type of prescription, simply:

1. Take the prescription to a participating ESI network pharmacy,
2. Identify yourself as an eligible Local 73 Welfare Fund Participant (for instance, by showing your prescription drug plan card), and
3. Pay the required copayment and any deductible as shown in the *Schedule of Benefits* on pages 6 and 7 and you will receive the prescription drug with no additional paperwork or charge.

The retail pharmacy network is offered through Express Scripts, Inc. ("ESI") national network of pharmacies. To find out whether a particular pharmacy is a participating network pharmacy, call an ESI customer service representative at 1-866-544-2916 or visit the ESI website at www.express-scripts.com. Members are able to obtain both 34 day acute medication as well as maintenance medications for 90 days through retail pharmacies. For long-term medications, it is encouraged to utilize the mail order facility. Use a network retail pharmacy for an emergency or one-time prescription and the mail order service for a long-term prescription.

If you use a non-participating network pharmacy, you must pay for the entire cost of the medication when the prescription is filled. You must then complete an ESI Claim Form and submit it along with the original prescription receipt to the ESI Claims Department. You will be reimbursed at the negotiated pharmacy rate less the appropriate copayment.

You may obtain an ESI Claim Form by calling ESI at 1-866-544-2916 , visiting its website at www.express-scripts.com, or contacting the Fund Office.

Mail Order Prescription Drug Service

If your Physician has prescribed a maintenance medication (long-term treatment), you should have your prescription filled by the mail order program. The mail order prescription drug service is administered by ESI.

To fill a maintenance prescription through ESI, simply:

1. Obtain a new written prescription for each covered medication. ESI can only dispense the amount of medication your Physician has prescribed up to a ninety (90) day supply. Show your Physician the material attached to the Prescription Drug Benefits brochure to help him or her write a prescription for this program.
2. Complete the Mail Service Order Form/Patient Profile.
3. Mail the written prescription, the profile, the order form and your copayment to ESI at the address on ESI's order form. The copayment for each prescription order is shown in the applicable *Schedule of Benefits* on pages 6 and 7. If you need assistance determining the copayment amount, call ESI at 1-866-544-2916 or visit their website at www.express-scripts.com.

You will receive refill labels (if refills remain) and a new order form in your prescription package. To obtain a refill order, simply affix the refill label to the back of the order form and send it to ESI. If you have no refills remaining or if your prescription has expired, contact your Physician for a new written prescription to send to ESI.

If you have a question about your prescription, call ESI at 1-866-544-2916 to speak with a Customer Service Representative.

Contraceptives

All forms of contraceptives including medicines and devices (IUD-patches) are reviewed and covered.

Prescription Drug Exclusions and Limitations

Benefits are not payable under Prescription Drug Benefits for:

1. Medicines or drugs obtainable without a Physician's prescription, except insulin,
2. Medications used for cosmetic purposes, including Vitamin A derivatives (retinoids) for dermatological use (i.e., Retin A, Renova),
3. Vitamins and nutritional supplements (except as provided under the Preventive Services Benefit),
4. Smoking deterrents (except as provided under the Preventive Services Benefit or Wellness Benefit, as applicable),
5. Fertility drugs (except as provided under the Infertility Benefit),
6. Viagra and other erectile dysfunction drugs are reviewed and covered by ESI. Prescription Drugs prescribed by the treating Physician to treat erectile dysfunction will be covered if:
    a) You have or had one of the following: Prostate and testicular cancer, disorders of the prostate (including prostatic enlargement and hyperplasia), low testosterone level, Diabetes, Crohn's disease, Peripheral neuropathy, Hypertension and other vascular conditions, or erectile dysfunction as a side effect from another prescription medication or combination of medications that can be verified as a side effect, which is listed in the *Physician's Desk Reference*; and
    b) You provide the following information: A letter of Medical Necessity from your attending Physician, complete diagnosis, and name and dosage of medication prescribed.

    Re-verification from the Physician is required every twelve (12) month period.

7. Anabolic steroids,
8. Weight control or drugs or anorexiants, except those used for treatment of Children with attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD), or individuals with narcolepsy,
9. Serum allergy antigen solutions,
10. Existing and new drugs that are not uniformly and professionally endorsed by the general medical community for prescription in the course of standard medical care, including existing and new drugs that are experimental in nature, and
11. Gene therapy prescription drugs regardless of where such drugs are administered.

Prescription Drug Benefits Coordination with Medicare Part D

If you or your Eligible Dependents are eligible for and enroll in Medicare Part D, the Plan will not provide you with the Prescription Drug Benefits and will not coordinate benefits with Medicare Part D benefits.

If you or your Eligible Dependent are eligible for but do not enroll in Medicare Part D, the Plan will continue to provide your Prescription Drug Benefits.

Death Benefit (Retirees Only)

The Fund provides a taxable benefit for your survivors or your Beneficiary in the event of your death. Your Beneficiary does not need to submit a claim form, but must submit a certified copy of your death certificate. After the Fund Office receives the official death certificate showing that you have died, the Fund will pay your Beneficiary the amount shown in the applicable *Schedule of Benefits* on pages 4 and 7.

Payment will be made in a lump sum to your Beneficiary on record at the Welfare Fund Office. If you have not designated a Beneficiary to receive your death benefits under the Fund or if your Beneficiary dies before you, your Death Benefit will be paid to the following persons, if living, in the following order and priority:

1. Your spouse,
2. Your surviving Children, in equal shares,
3. Your father,
4. Your mother,
5. Your brothers and sisters, in equal shares, or
6. The personal representative of your estate.

The Beneficiary you name for your Death Benefit is also your Beneficiary for your Accidental Death and Dismemberment Benefit.

If the Death Benefit becomes payable to a person who is under 21 years of age, the amount may be paid to the person who is under 21 years of age without requiring the appointment of a guardian, by paying the amount to any person over the age of 21 years who:

1. Submits satisfactory proof to the Board of Trustees that he or she is supporting and maintaining the person who is under 21 years of age; and
2. Gives assurance satisfactory to the Board of Trustees that the money paid to him or her will be used to support and maintain the person who is under 21 years of age.

You may change your Beneficiary at any time by obtaining the proper form from the Welfare Fund Office and then completing and returning it to the Fund Office.

Once you retire, your death benefit coverage is terminated six (6) months after the effective date of your retirement. If you are no longer eligible under the Plan for any other reason, you are no longer eligible for the Death Benefit.

Accidental Death and Dismemberment Benefits (Retirees Only)

If you suffer any of the losses described below as a result of Sickness or bodily Injury, the Fund will pay the amount specified in the applicable *Schedule of Benefits* on pages 4 and 7. You must submit a letter from your Physician for accidental dismemberment benefits. If the claim is for your accidental death, your Beneficiary need only submit a certified copy of your death certificate.

Covered losses include:

- **Accidental Death**;
- **Two Accidental Dismemberments**, which include the loss of:
  - Both hands,
  - Both feet,
  - The sight of both eyes,
  - One (1) hand and one (1) foot,
  - One (1) hand and the sight of one (1) eye,
  - One (1) foot and the sight of one (1) eye; and
- **One Accidental Dismemberment**, which includes the loss of:
  - One (1) hand,
  - One (1) foot, or
  - The sight of one (1) eye.

  With respect to the loss of sight in one or both eyes, you are eligible for Accidental Dismemberment Benefits for loss of sight if you are deemed to be "legally blind" in one or both eyes under the laws of the United States.

Accidental Death Benefits will be paid if you die as a direct result of bodily Injury caused solely by an accident and you die within ninety (90) days from the date of the accident. No more than the amount listed in the *Schedule of Benefits* on page 4 and 7 will be paid for losses resulting from any one (1) event. Benefits for Accidental Death will be paid to the Beneficiary you have named to receive your Death Benefits, in the order provided on page 69.

Accidental Dismemberment Benefits will be paid if the dismemberment is a direct result of bodily Injury caused solely by an accident and the dismemberment occurs within ninety (90) days from the date of the accident. Accidental Dismemberment Benefits will be paid to you, or to the person caring for you, if you are unable to care for yourself. No more than $15,000 will be paid for losses resulting from any one event.

Once you retire, your eligibility for the Accidental Death and Dismemberment Benefit terminates six (6) months after the effective date of your retirement. If you are no longer eligible under the Plan for any other reason, you are no longer eligible for the Accidental Death and Dismemberment Benefit.

General Exclusions and Limitations

Benefits are not provided under the Plan for the following:

1. Any charges for services or supplies that are not Medically Necessary.
2. Any portion of the expenses for covered medical services or supplies that exceed the Reasonable and Customary Charge as defined in the *Definitions* section beginning on page 109.
3. Any bodily Injury or Sickness arising out of or in the course of employment or which is compensable under any Workers' Compensation or Occupational Disease Act or law.
4. Any charges made by a Hospital unless the hospitalization is recommended and approved by a Physician.
5. Surgery or medical treatment to improve or preserve physical appearance but not physical function. Cosmetic Surgery or treatment includes, but is not limited to, removal of tattoos, breast augmentation, or other medical or surgical treatment intended to restore or improve physical appearance. The Plan does cover Medically Necessary reconstructive procedures that are necessary to correct damage caused by a congenital birth defect or an Injury, as provided in Item 24 under *Covered Expenses* beginning on page 38. The Plan does cover reconstructive surgery after a mastectomy, as provided in Item 28 under *Covered Expenses* beginning on page 39.
6. Dental care and treatment, except (a) that necessitated by bodily Injury to sound, natural teeth, or (b) as specifically provided under the Dental Benefits.
7. Eye examinations and eyeglasses, except as provided under the Optical Benefits. However, the first pair of glasses purchased after cataract surgery is paid under the Major Medical Benefit.
8. Routine physical examinations and immunizations, except as specifically provided under the Wellness Benefit for Medicare Eligible Retirees and their spouses or the Preventive Services Benefit for Non-Medicare Eligible Retirees and their Dependents.
9. A bodily Injury or Sickness caused by war or by any act of war, declared or undeclared, or by participating in a riot or as the result of the commission of a felony by an eligible person, except that the Plan will cover Injuries and Sickness resulting from domestic violence.
10. Expenses for services provided without charge to the covered individual under any government-provided plan or program (including, without limitation, TRICARE (formerly known as CHAMPUS) and VA programs) established under the laws or regulations of any government, including the federal, state, or local government or the government of any other political subdivision of the United States, or of any other country or any political subdivision of any country; or under any plan or program in which any government participates other than as an Employer, unless the governmental program provides otherwise.
11. Charges made by a Physician, Registered Nurse (RN), Licensed Practical Nurse (LPN), Physiotherapist or any other Provider who is related to you or your Dependent or who ordinarily resides with you or your Dependents.
12. Charges made for Outpatient treatment, unless provided by a Health Care Provider who is:
    a) Legally licensed or legally authorized to practice or provide care or treatment for such conditions under State law or the jurisdiction where the services are rendered;
    b) Acting within the scope of that license, and
    c) Not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

13. Expenses for naturopathic, naprapathic, and/or homeopathic services or treatments/ supplies. Expenses for chelation therapy, except as Medically Necessary for the treatment of acute arsenic, gold, mercury, or lead poisoning, and for diseases due to clearly demonstrated excess of copper or iron.

14. Expenses for medical or surgical treatment of weight-related disorders and obesity (except as provided in Item 16 in the *Covered Expenses* section beginning on page 33), including but not limited to gastric by-pass procedures, intestinal bypass and reversal procedures, weight-loss programs, dietary instructions, Prescription Drugs and any complications thereof, even if those procedures are performed to treat a co-morbid or underlying condition.

15. Charges for smoking cessation programs, treatments or devices, except as provided under the Wellness Benefit for Medicare Eligible Retirees and their spouses or the Preventive Services Benefit for Non-Medicare Eligible Retirees and their Dependents.

16. Medicines or drugs that can be obtained without a Physician's prescription.

17. Foods and nutritional supplements including, but not limited to, home medications, formulas, foods, diets, vitamins, herbs and minerals (whether over the counter or prescription), except when provided during hospitalization.

18. Any expense or charge for the promotion of fertility, except as provided in the applicable *Schedule of Benefits* on page 6 and Item 30 in the *Covered Expenses* section beginning on page 39. Expenses not covered for the promotion of fertility include, but are not limited to the following:

    a) Reversal of voluntary sterilization,

    b) Payment of medical services rendered to a surrogate for purposes of childbirth,

    c) Costs associated with CRYO preservation and storage of sperm, eggs and embryos. However, procedures that use the CRYO preserved substance may not be excluded,

    d) Selected termination of an embryo. However, if the life of the mother would be in danger if all embryos were carried to full term, termination is covered,

    e) Non-medical cost of an egg or sperm donor,

    f) Travel costs not Medically Necessary, or

    g) Experimental infertility treatments. However, if an infertility treatment includes elements not experimental in nature along with those that are, the non-experimental services are covered as long as they are listed in the applicable *Schedule of Benefits* on page 6 and Item 30 in the *Covered Expenses* section beginning on page 33.

19. Genetic testing, except as otherwise covered under the Plan, including:

    a) An analysis of proteins or metabolites that does not detect genotypes, mutations or chromosomal changes; and

    b) A medical examination that tests for the presence of a virus that is not composed of human DNA, RNA, chromosomes, proteins or metabolites;

    c) A test for infectious and communicable diseases that may be transmitted through food handling;

    d) Complete blood counts, cholesterol tests and liver-function tests;

    e) HLA typing to determine a transplant match;

    f) A test for the presence of alcohol or illegal drugs; and

g) A test to determine whether an individual has a genetic predisposition for alcoholism or drug use.

20. Any expense or charge for orthoptics, eye exercises or vision training and supplies, except as provided under the covered expenses.

21. Vision therapy and orthoptics for perceptual or visual motor coordination problems due to conditions such as minimal brain dysfunction, integrative dysfunction, dyslexia, etc., and problems with the interpretation of visual input to the brain and the reaction and output of the brain in response to such stimuli.

22. Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums and/or facilities for physical fitness programs, including exercise equipment.

23. Expenses for construction or modification to a home, residence or vehicle required as a result of Injury, Sickness or disability, including without limitation construction or modification of ramps, elevators, chair lifts, swimming pools, spas, air conditioning, asbestos removal, home traction unit, air filtration, handrails, emergency alert system, etc.

24. Any expense for a mechanical heart implant.

25. Foot-care treatment for:

    a) Weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, except open cutting operations, and

    b) Corns, calluses or toenails, except the removal of nail roots and routine foot care from a podiatrist for individuals with diabetes or a neurological or vascular disorder affecting the feet.

26. Rest cures, domiciliary care, convalescent care or custodial care, which is care provided primarily for convenience or to assist the patient in the activities of daily living when the constant attention of trained medical personnel is not required. Also excluded are expenses for the services of private duty nurses, except when Medically Necessary.

27. Acupuncture, acupressure or hypnosis, unless performed by a licensed Physician or other appropriately licensed Non-Physician Provider for a Medically Necessary reason.

28. Any treatment (surgical or non-surgical) of the temporomandibular joint dysfunction (TMJ or TMD).

29. Expenses for hair removal or hair transplants and other procedures to replace lost hair or to promote the growth of hair, including prescription and non-prescription drugs such as Minoxidil, Propecin, Rogaine, or Vaniga; or for hair replacement devices including, but not limited to, wigs, toupees, and/or hairpieces or hair analysis. However, wigs or other cranial prosthesis are covered up to $500 per person per calendar year with written approval from a physician for the loss of hair due to treatment of a malignancy (chemotherapy, radiation) or permanent hair loss from an accident or Alopecia. =

30. Rehabilitation therapy expenses including expenses for:

    a) Education, job training, vocational rehabilitation and/or special education for sign language,

    b) Massage therapy, rolfing and related services,

    c) Inpatient rehabilitation facility services provided to an individual who is unconscious, comatose or otherwise incapable of conscious participation in the therapy services and/or unable to learn and/or remember what is taught, including but not limited to coma stimulation programs and services,

d) Maintenance rehabilitation,

e) Speech therapy (unless it is due to stroke, surgery on vocal chords or neurological Injury). Speech therapy for functional purposes including but not limited to stuttering, stammering and conditions of psychoneurotic origin, or for developmental speech delays, and

f) Treatment of delays in childhood speech development unless as a direct result of an Injury, surgery or result of a covered treatment.

31. Personal comfort items and expenses for patient convenience including but not limited to care of family members while the covered individual is confined to a Hospital or other covered healthcare facility or in bed at home, including guest meals, television, rental of DVDs or VCRs or devices to play them, telephone, personal hygiene items, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.

32. Expenses for an autopsy and any related expenses.

33. Expenses for preparing medical reports, bills or claim forms; mailing, shipping or handling expenses; and charges for broken/missed appointments, telephone calls and/or photocopying fees.

34. Expenses for educational services, supplies or equipment, including, but not limited to, computers, software, printers, books, tutoring, visual aids, auditory aides, speech aids, programs to assist with auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation or self-esteem, etc., even if they are required because of an Injury, Sickness or disability of a covered individual.

35. Expenses that exceed any Plan benefit limitations.

36. Expenses for services or supplies for which a third party is required to pay because of the negligence or other tortious or wrongful act of that third party. See the provisions relating to subrogation, reimbursement, and third-party liability on page 101 for an explanation of the circumstances under which the Plan will pay benefits until it is determined that the third party is required to pay for those services or supplies.

37. Expenses for any medical services, supplies, or drugs or medicines determined to be Experimental or Investigative as defined in the *Definitions* section on page 109.

38. Expenses for and related to non-emergency travel or transportation (including lodging, meals and related expenses) of a healthcare Provider, Participant or family member of a covered individual.

39. Expenses for any Physician or other healthcare Provider who did not directly provide or supervise medical services to the patient, even if the Physician or healthcare Provider was available to do so on a stand-by basis.

40. The following behavioral health exclusions:

a) Expenses for hypnosis, hypnotherapy and/or biofeedback, except as determined to be Medically Necessary and as provided by a licensed Physician.

b) Expenses for behavioral healthcare services related to adoption counseling; autism; court-ordered behavioral healthcare services; custody counseling; developmental disabilities; dyslexia; learning disorders; family planning counseling; genetic testing and counseling (see also the exclusion regarding genetic testing and counseling in Item 20 of this section); marriage, couples, and/or sex counseling; mental retardation; pregnancy counseling; and vocational disabilities.

41. The following custodial care expenses:

a) Expenses for care that is custodial in nature, regardless of where care is provided, including without limitation adult day care, child day care, services of a homemaker, or personal care, sitter/companion service.

b) Services required to be performed by Physicians or other covered Providers are **not** considered to be provided for custodial care services and are covered if they are determined to be Medically Necessary. However, any services that can be learned to be performed or provided by a family member who is not a Physician or other covered Provider are **not covered**, even if they are Medically Necessary.

42. Pharmaceuticals requiring a prescription that have not been approved by the U.S. Food and Drug Administration (FDA) or are not approved by the FDA for the condition, dose, route and frequency for which they are prescribed (i.e., are used "off-label") or are Experimental and/or Investigative, as defined in the *Definitions* section on page 109. Take-home drugs or medicines provided by a Hospital, Emergency Room, Outpatient Surgical Center, or other healthcare facility (except as required for Approved Clinical Trials, as required under the Affordable Care Act).

43. Expenses for and related to the purchase, servicing, fitting and/or repair of hearing aid devices and special education and associated costs in conjunction with sign language education for a patient or family members, except as provided under the Hearing Aid Benefit and the Cochlear Implant benefit described in the *Schedule of Benefits*.

44. Expenses related to cryostorage of umbilical cord blood or other tissue or organs.

45. Expenses for all medical or surgical services or procedures, including Prescription Drugs and the use of prophylactic surgery, when the services, procedures, prescription of drugs, or prophylactic surgery is prescribed or performed for the purpose of:

a) Avoiding the possibility or risk of a Sickness, disease, physical or mental disorder or condition based on family history and/or genetic test results; or

b) Treating the consequences of chromosomal abnormalities or genetically transmitted characteristics when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder.

46. Expenses for surgical correction of refractive errors and refractive keratoplasty procedures including, but not limited to, Radial Keratotomy (RK) and Automated Keratoplasty (ALK), or Laser In Situ Keratomileusis (LASIK).

47. Orthokeratology lenses for reshaping the cornea of the eye to improve vision.

48. Expenses for Durable Medical Equipment, except as provided on page 116.

49. Growth hormone (except as Medically Necessary for Dependent Children).

50. Room and board charges incurred for stays off the premises of the facility at which you are receiving treatment.

51. All gene therapy treatments, including gene therapy prescription drugs regardless of where such drugs are administered.

52. Any expenses related to non-emergency services while traveling outside of the United States for any reason.

How to File a Claim

Internal Claims and Appeal Procedures

This section describes the procedures followed by the Sheet Metal Workers' Local 73 Welfare Fund Plan for Retired Members in making internal claim decisions and reviewing appeals of denied claims. These procedures apply to claims for medical, mental health, substance abuse, dental, vision, hearing, wellness, prescription drug, death, and accidental death and dismemberment benefits.

The Plan's internal claims and appeal procedures are designed to provide you with full, fair, and fast claim review and so that Plan provisions are applied consistently with respect to you and other similarly situated participants and Dependents. With respect to health benefit claims, the Plan must consult with a health care professional with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary or appropriate, or is Experimental or Investigational).

The internal claims process pertains to determinations made by the appropriate Claims Administrator about whether a request for benefits (known as an initial "claim") is payable. If the appropriate Claims Administrator denies your initial claim for benefits (known as an "adverse benefit determination"), you have the right to appeal the denied claim under the Plan's internal appeals process.

For health benefits, you may be able to seek an external review with an Independent Review Organization (IRO) that conducts reviews of adverse benefit determinations either (i) after the Plan's internal appeals process has been exhausted, or (ii) under limited circumstances before the Plan's internal claims and appeals process have been exhausted.

General Information

Claims Administrator(s)

The Plan Administrator has delegated responsibility for initial claims decisions to the following companies/organizations:

Appropriate Claims Administrator	Types of Claims Processed
Fund Administrator, 4530 Roosevelt Road, Hillside, IL 60162, 1-708-449-7373, www.sm73funds.org	• Medical Post-Service Claims
Blue Cross Blue Shield Medical Services Advisory for Hospital admissions/inpatient medical services, P.O. Box 805107, Chicago, IL 60680-4112, 1-800-255-5192, www.bcbsil.com; Blue Cross Blue Shield Behavioral Health Services, P.O. Box 805107, Chicago, IL 60680-4112, 1-800-851-7498, www.bcbsil.com	• Urgent Care, Concurrent and Pre-Service Medical Claims
Delta Dental of Illinois	• Dental Benefit Claims

Appropriate Claims Administrator	Types of Claims Processed
1-800-523-1743 www.deltadentalil.com	
Valenz Care Medical Services Advisory 1-800-367-1934 Fax: 1-312-236-8547 23048 N. 15th Ave. Phoenix, AZ 85027 www.valenzhealth.com	• All required pre-admission authorization • Urgent Care Concurrent and Pre-Service Claims may require pre-admission authorization. Refer to the Utilization Management section at page 28 for additional information.
Fund Administrator, 4530 Roosevelt Road, Hillside, IL 60162, 1-708-449-7373, www.sm73funds.org	• Pre-Service Claims • Mental Health Urgent Care, Concurrent and Pre-Service Claims
Express Scripts (ESI), 1-866-544-2916, www.express-scripts.com	• Pre-Service Claims for prescription drugs • Post-Service Claims for out–of-network retail prescription drugs
EyeMed, PO Box 8504, Cincinnati, OH 45040-7111, 1-866-723-0514, www.eyemedvisioncare.com	• Pre-Service Claims for vision benefits • Post-Service Claims for vision benefits
Fund Administrator, 4530 Roosevelt Road, Hillside, IL 60162, 1-708-449-7373, www.sm73funds.org	• Post-Service hearing benefit claims
Fund Administrator, 4530 Roosevelt Road, Hillside, IL 60162, 1-708-449-7373, www.sm73funds.org	• Death Benefit Claims • Accidental Death and Dismemberment Claims

Days Defined

For the purpose of the initial claims and appeal processes, "days" refers to calendar days, not business days.

Discretionary Authority of Plan Administrator and Designees

In carrying out their respective responsibilities under the Plan, the Plan Administrator, Fund Administrator, other Plan fiduciaries, Claims Administrators, and other individuals to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to interpret the terms of the Plan and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Adverse Benefit Determination

An adverse benefit determination, for the purpose of the internal claims and appeal process, means:

- A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in the Plan or a determination that a benefit is not a covered benefit;

- A reduction of a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion, or other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be not Medically Necessary or appropriate, or Experimental or Investigational; or

- A rescission of coverage, whether or not there is an adverse effect on any particular health benefit. An adverse benefit determination does not include rescissions of coverage with respect to accidental death and dismemberment insurance/death benefits.

Health Care Professional

A health care professional, for the purposes of the claims and appeals provisions, means a Physician or other health care professional licensed, accredited or certified to perform specified health services consistent with State law.

Culturally and Linguistically Appropriate Notices

All notices sent to claimants relating to internal claims and appeal review for health benefits will contain a notice about the availability of Spanish language services. Assistance with filing a claim for internal review in Spanish is available by calling 1-708-449-2123. Notices relating to internal review will be provided in Spanish upon request.

SPANISH (Español): Para obtener asistencia en Español, llame al 1-708-449-2123.

Definition of a Claim

A claim is a request for a Plan benefit made by you or your covered Dependent (also referred to as "claimant") or your authorized representative in accordance with the Plan's reasonable claims procedures.

Types of Claims

Health Benefit Claims

Health benefit claims can be filed for medical, mental health, substance abuse, dental, vision, hearing, wellness/preventive care, and prescription drug benefits.

There are four categories of health claims as described below:

- ***Pre-Service Claims*** **(applicable to medical, mental health, substance abuse, and prescription drug benefits)** - A Pre-Service Claim is a claim for a benefit that requires approval of the benefit (in whole or in part) before health care is obtained. Under this Plan, prior approval is required for medical, mental health, substance abuse, and prescription drug benefits.

- ***Urgent Care Claims*** **(applicable to medical, mental health, substance abuse, and prescription**

drug benefits) – An Urgent Care Claim is any Pre-Service Claim for health care treatment that (i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (ii) in the opinion of the claimant's attending Health Care Provider with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. However, the Plan will not deny benefits for these procedures or services if it is not possible for the claimant to obtain the pre-approval, or the pre-approval process would jeopardize the claimant's life or health.

- ***Concurrent Claims*** **(applicable to medical, mental health, substance abuse, and prescription drug benefits)** - A Concurrent Claim is a claim that is reconsidered after an initial approval has been made and results in a reduced or terminated benefit. Also, a Concurrent Claim can pertain to a request for an extension of a previously approved treatment or service.

- ***Post-Service Claims*** **(applicable to medical, mental health, substance abuse, dental, vision, hearing, wellness/preventive care, and prescription drug benefits)** - A Post-Service Claim is a request for benefits under the Plan that is not a Pre-Service Claim. Post-Service Claims are requests that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim or electronic bill submitted for payment after services have been provided are examples of a Post-Service Claim. A claim regarding the rescission of coverage will be considered to be a Post-Service Claim.

Accidental Death and Dismemberment Insurance/Death Benefit Claims

An Accidental Death and Dismemberment Insurance/Death Benefit Claim is a request by a designated beneficiary for benefit payment following the death of the participant or the death of a covered Dependent. A claim for Accidental Death and Dismemberment Benefits may also be filed by a participant after he or she has provided the Plan with proof of a bodily loss.

Claim Elements

An initial claim must include the following elements to trigger the Plan's internal claims process:

- Be written or electronically submitted (oral communication is acceptable only for Urgent Care Claims);
- Be received by the Fund Administrator or Claims Administrator (as applicable);
- Name a specific individual participant and his/her Social Security Number;
- Name a specific claimant and his/her date of birth;
- Name a specific medical condition or symptom;
- Provide a description and date of a specific treatment, service or product for which approval or payment is requested (must include an itemized detail of charges);
- Identify the provider's name, address, phone number, professional degree or license, and federal tax identification number (TIN); and

- When another plan is primary payer, include a copy of the other Plan's Explanation of Benefits (EOB) statement along with the submitted claim.

A request is *not* a claim if it is:

- Not made in accordance with the Plan's benefit claims filing procedures described in this section;
- Made by someone other than you, your covered Dependent, or your (or your covered Dependent's) authorized representative;
- Made by a person who will not identify himself or herself (anonymous);
- A casual inquiry about benefits such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
- A request for prior approval where prior approval is not required by the Plan;
- An eligibility inquiry that does not request benefits. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and the individual will be notified of the decision and allowed to file an appeal;
- The presentation of a prescription to a retail pharmacy or mail order pharmacy that the pharmacy denies at the point of sale. After the denial by the pharmacy, you may file a claim with the Plan;
- A request for an eye exam, lenses, frames or contact lenses that is denied at the point of sale from the Plan's contracted in-network vision provider(s). After the denial by the vision service provider, you may file a claim with the Plan.

If you submit a claim that is not complete or lacks required supporting documents, the Fund Administrator or Claims Administrator, as applicable, will notify you about what information is necessary to complete the claim. This does not apply to simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim or which relate to proposed or anticipated treatment or services that do not require prior approval.

Initial Claim Decision Timeframes

Claim Filing Deadline

There is a two-year period beginning with the date you incur charges for medical services (including wellness/preventive care, hearing, optical services and accident and sickness) during which you must file a claim for reimbursement of the charges.

There is a one-year period beginning with the date you incur charges for prescription drug claims during which you must file a claim for reimbursement of the charges.

If you file a claim after this two-year period, or one-year period in the case of prescription drug benefits, no reimbursement will be made.

The time period for making a decision on an initial claim request starts as soon as the claim is received by the appropriate Claims Administrator, provided it is filed in accordance with the Plan's reasonable filing

procedures, regardless of whether the Plan has all of the information necessary to decide the claim. A claim may be filed by you, your covered Dependent, an authorized representative, or by a network provider. In the event a claim is filed by a provider, the provider will not automatically be considered to be your authorized representative.

Health Care Claims – Decision Timeframes

The Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which notice of an adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

- **Pre-Service Claims (applicable to medical, mental health, substance abuse, and prescription drug benefits)**

  Claims for Pre-Service (that are not for Urgent Care) will be decided no later than fifteen (15) days after receipt by the appropriate Claims Administrator. You will be notified in writing (or electronically, as applicable) within the initial fifteen (15) day period whether the claim was approved or denied (in whole or in part).

  The time for deciding the claim may be extended by up to fifteen (15) days due to circumstances beyond the Claims Administrator's control (e.g., inability of a medical reviewer to meet a deadline); provided you are given written (or electronic, if applicable) notification before the expiration of the initial fifteen (15) day determination period.

  If you improperly file a Pre-Service Claim, the Claims Administrator will notify you in writing (or electronically, as applicable) as soon as possible, but in no event later than five (5) days after receiving the claim. The notice will describe the proper procedures for filing a Pre-Service Claim. Thereafter, you must re-file a claim to begin the Pre-Service Claim determination process.

  If a claim cannot be processed due to insufficient information, the Claims Administrator will notify you in writing (or electronically, as applicable) about what specific information is needed before the expiration of the initial fifteen (15) day determination period. Thereafter, you will have forty-five (45) days following your receipt of the notice to supply the additional information. If you do not provide the information during the forty-five (45) day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision is suspended. The claim decision deadline is suspended until the earlier of forty-five (45) days or the date the Claims Administrator receives your response to the request for information. The Claims Administrator then has fifteen (15) days to make a decision and notify you in writing (or electronically, as applicable).

- **Urgent Care Claims (applicable to medical, mental health, substance abuse, and prescription drug benefits)**

  In the case of an Urgent Care Claim, if a health care professional with knowledge of your medical condition determines that a claim constitutes an Urgent Care Claim, the health care professional

will be considered by the Plan to be your authorized representative bypassing the need for completion of the Plan's written authorized representative form.

The appropriate Claims Administrator will decide claims for Urgent Care as soon as possible, but in no event later than seventy-two (72) hours after receipt of the claim. The Claims Administrator will orally communicate its decision telephonically to you. The determination will also be confirmed in writing (or electronically, as applicable) no later than three (3) days after the oral notification.

If you improperly file an Urgent Care Claim, the Claims Administrator will notify you, as soon as possible, but in no event later than twenty-four (24) hours after receiving the claim. The written (or electronic, as applicable) notice will describe the proper procedures for filing an Urgent Care Claim. Thereafter, you must re-file a claim to begin the Urgent Care Claim determination process.

If a claim cannot be processed due to insufficient information, the Claims Administrator will provide you with a written (or electronic, as applicable) notification about what specific information is needed as soon as possible and no later than twenty-four (24) hours after receipt of the claim. Thereafter, you will have not less than forty-eight (48) hours following receipt of the notice to supply the additional information. If you do not provide the information during the period, the claim will be denied (i.e., an adverse benefit determination). Written (or electronic, as applicable) notice of the decision will be provided to you no later than forty-eight (48) hours after the Claims Administrator receives the specific information or the end or the period given for you to provide this information, whichever is earlier.

- **<u>Concurrent Claims</u> (applicable to medical, mental health, substance abuse, and prescription drug benefits)**

  If a decision is made to reduce or terminate an approved course of treatment, you will be provided with a written (or electronic, as applicable) notification of the termination or reduction sufficiently in advance of the reduction or termination to allow you to request an appeal and obtain a determination of that adverse benefit determination before the benefit is reduced or terminated.

  A Concurrent Claim that is an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes described above under the Urgent Care Claim section.

  A Concurrent Claim that is not an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes applicable to the Pre-Service or Post-Service Claim, as applicable, provisions described above in this section.

  If the Concurrent Care Claim is approved you will be notified orally followed by written (or electronic, as applicable) notice provided no later than three (3) calendar days after the oral notice.

  If the Concurrent Care Claim is denied, in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice.

- **<u>Post-Service Claims</u> (applicable to medical, mental health, substance abuse, dental, vision, hearing, wellness/preventive care, and prescription drug claims)**

  Claims for Post-Service treatments or services will be decided no later than thirty (30) days after receipt by the appropriate Claims Administrator. You will be notified in writing (or electronically, as applicable) within the thirty (30) day initial determination period if the claim is denied (in whole or in part).

The time for deciding the claim may be extended by fifteen (15) days due to circumstances beyond the Claim Administrator's control (e.g., inability of a medical reviewer to meet a deadline); provided you are given written (or electronic, as applicable) notification before the expiration of the initial thirty (30) day determination period.

If a claim cannot be processed due to insufficient information, the Claim Administrator will notify you in writing (or electronically, as applicable) about what information is needed before the expiration of the initial thirty (30) day determination period. Thereafter, you will have forty-five (45) days after your receipt of the notice to supply the additional information. If you do not provide the information during the forty-five (45) day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision on the claim is suspended. The claim decision deadline is suspended until the earlier of forty-five (45) days or until the date the Claims Administrator receives your written response to the request for information. The Claims Administrator then has fifteen (15) days to make a decision and notify you in writing (or electronically, as applicable).

Accidental Death and Dismemberment Insurance or Death Benefit – Decision Timeframe

Generally, you will receive written (or electronic, as applicable) notice of a decision on your initial claim within ninety (90) days of receipt of your claim by the Claims Administrator. If additional time or information is required to make a determination on your claim (for reasons beyond the control of the Claims Administrator, you will be notified in writing (or electronically, as applicable) within the initial ninety (90) day determination period. The ninety (90) day period may be extended up to an additional ninety (90) days.

Initial Determinations of Benefit Claims

Notice of Adverse Benefit Determination

If the Claims Administrator denies your initial claim, in whole or in part, you will be given a notice about the denial (known as a "notice of adverse benefit determination"). The notice of adverse benefit determination will be given to you in writing (or electronically, as applicable) within the timeframe required to make a decision on a particular type of claim. The notice of adverse determination must:

- Identify the claim involved (and for health benefit claims – include the date of service, Health Care Provider, claim amount if applicable, denial code and its corresponding meaning);
- Give the specific reason(s) for the denial (and for health benefit claims - include a statement that the claimant has the right to request the applicable diagnosis and treatment code and their corresponding meanings; however such a request is not considered to be a request for an internal appeal or external review for health benefit claims);
- If the denial is based on a Plan standard that was used in denying the claim, a description of such standard.
- Reference the specific Plan provision(s) on which the denial is based;
- Describe any additional material or information needed to perfect the claim and an explanation of why such added information is necessary;
- With respect to health claims, the opportunity, upon request and without charge, reasonable access

to and copies of all documents, records and other information relevant to an initial claim for benefits;

- Provide an explanation of the Plan's internal appeal and external review for health benefit claims processes along with time limits and information about how to initiate an appeal and an external review for health benefit claims;

- Contain a statement that you have the right to bring civil action under ERISA section 502(a) following an appeal;

- With respect to health claims, if the denial was based on an internal rule, guideline, protocol, standard, or similar criteria, a statement will be provided that a copy of such rule, guideline, protocol or similar criteria that was relied upon will provided to you free-of-charge upon request;

- If the denial of a health claim was based on Medical Necessity, Experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided to you free-of-charge upon request;

- For Urgent Care health benefit claims, the notice will describe the expedited internal appeal and external review processes applicable to Urgent Care Claims. In addition, the required determination may be provided orally and followed with written (or electronic, as applicable) notification; and

- With respect to health benefit claims, provide information about the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with the Plan's internal claims and appeal processes as well as with the external review process.

Notice of Approval of Pre-Service and Urgent Care Claims

If a Pre-Service claim is approved, you will receive written (or electronic, as applicable) notice within fifteen (15) days of the appropriate Claims Administrator's receipt of the claim. Notice of approval of an Urgent Care Claim will be provided in writing (or electronically, as applicable) to you within the applicable timeframe after the Claims Administrator's receipt of the claim.

Internal Appeal Request Deadline

- ***Health Care Claims*** **(applicable to medical, mental health, substance abuse, dental, vision, hearing, wellness/preventive care, and prescription drug benefits)**

  If an initial health care claim is denied (in whole or in part) and you disagree with the Claims Administrator's decision, you or your authorized representative may request an internal appeal. You have one hundred and eighty (180) calendar days following receipt of a notice of adverse benefit determination to submit a written request for an internal appeal. The Plan will not accept appeals filed after this one hundred and eighty (180) day period. Under limited circumstances, explained below in the section on External Review, you may bypass the Plan's internal claims and/or appeal processes and file a request for an external review.

- ***Accidental Death and Dismemberment Insurance/Death Benefits***

  If an initial accidental death and dismemberment/death benefit claim is denied and you disagree with the Claims Administrator's decision, you or your authorized representative may request an appeal. You have sixty (60) calendar days following your receipt of an initial notice of adverse

benefit determination to submit a written request for an appeal. The Plan will not accept appeal requests filed after this sixty (60) day period.

Internal Appeals Process

Appeal Procedures

To file an internal appeal, you must submit a written statement to the Plan at the following address:

Board of Trustees c/o Benefits Appeal Committee
Sheet Metal Workers' Local 73 Welfare Fund
Plan for Retired Members
4530 Roosevelt Road
Hillside, IL 60162
1-708-449-7373
www.sm73funds.org

Appeal requests involving Urgent Care Claims may be made orally by calling the Board of Trustees at the telephone number listed above.

Your request for an internal appeal must include the specific reason(s) why you believe the initial claim denial was improper. You may submit any document that you feel is appropriate to the internal appeal determination, as well as submitting any written issues and comments.

As a part of its internal appeals process, the Plan will provide you with:

- The opportunity, upon request and without charge, reasonable access to and copies of all documents, records and other information relevant to your initial claim for benefits;

- The opportunity to submit to the Plan written comments, documents, records and other information relating to your initial claim for benefits;

- With respect to health benefit appeals, the Plan will automatically provide you with a reasonable opportunity to respond to new information by presenting written evidence and testimony;

- A full and fair review by the Plan that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim determination;

- With respect to health benefit claims, the Plan will automatically provide you free-of-charge, with any new or additional evidence or rationale considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied initial claim. The Plan will automatically provide you with any new or additional evidence or rationale as soon as possible once it becomes available to the Plan and sufficiently in advance of the date on which notice of an adverse determination on appeal is scheduled to be provided to you. New or additional evidence or rationale will be provided to you so that you have a reasonable opportunity, sufficiently in advance of the date on which a notice of an adverse benefit determination upon appeal is required to be provided, to respond to the Plan regarding such evidence. If the new or additional evidence or rationale is received by the Plan so late that it would be impossible to provide it to you in time for you to have a reasonable opportunity to respond, then the period for providing a notice of a final adverse benefit

determination will be delayed (tolled) until you have had a reasonable opportunity to respond. After you respond (or do not respond after having a reasonable opportunity to do so), the Plan (acting in a reasonable and prompt manner) will notify you of its benefit determination upon appeal as soon as it can provide a notice of determination, taking into account any medical exigencies;

- A review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate fiduciary or fiduciaries of the Plan who is neither the individual who made the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

- With respect to health benefit claims appeals, continued coverage during the pendency of the appeal process; and

- In deciding an appeal of any adverse benefit determination regarding a health benefit claim that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is Experimental, Investigational, not Medically Necessary or appropriate, the fiduciary or fiduciaries will:
    - Consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment; and
    - Is neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
    - The Plan will provide, upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

Appeal Determination Timeframes

- ***Health Care Claims***

    - ***Pre-Service Claims (applicable to medical, mental health, substance abuse, and prescription drug benefits).*** A determination will be made and a written (or electronic, as applicable) notice regarding the appeal will be sent to you within thirty (30) days from the date your written request for an appeal is received by the Plan. The Fund Administrator may extend the 30-day period due to special circumstances (e.g., the need to hold a hearing) if the claimant is notified of such extension within the initial thirty (30) day period. The extension cannot extend beyond sixty (60) days from the end of the initial thirty (30) day determination period.

        - ***Urgent Care Claims (applicable to medical, mental health, substance abuse, and prescription drug benefits).*** This is an expedited internal appeals process under which a written notice regarding a decision on the approval or denial of the expedited internal appeal will be sent to you no later than within seventy-two (72) hours of the Plan's receipt of your (oral or written) request for appeal. If your situation involves an urgent medical condition, which the timeframe for completing an expedited internal appeal would seriously jeopardize your ability to regain maximum function, and the claim involves a medical judgment or a rescission of coverage, you may seek an expedited external review at the same time that you request an expedited internal appeal (you must seek both).

        - **Concurrent Claims** ***(applicable to medical, mental health, substance abuse, and***

prescription drug benefits). You may request an internal appeal of a Concurrent Claim by submitting the request orally (for an Urgent Care Claim) or in writing to the Board of Trustees. A determination will be made on the internal appeal and you will be notified as soon as possible before the benefit is reduced or treatment is terminated.

- **Post-Service Claims** ***(applicable to medical, mental health, substance abuse, dental, vision, hearing, wellness/preventive care, and prescription drug benefits).*** A written (or electronic, as applicable) notice regarding the Plan's determination on the internal appeal will be sent to you within sixty (60) days from the date your written request for an appeal is received by the Plan. The Fund Administrator may extend the sixty (60) day period due to special circumstances (e.g., the need to hold a hearing) if the claimant is notified of such extension within the initial sixty (60) day period. The extension cannot extend beyond sixty (60) days from the end of the initial sixty (60) day determination period.

  The Plan will make an appeal determination no later than the date of the Board of Trustees' meeting immediately following the Plan's receipt of your written request for an internal appeal, unless the request for an internal appeal review is filed within thirty (30) calendar days preceding the date of such meeting. In such case, an appeal determination will be made no later than the date of the second meeting following the Plan's receipt of your written request for an appeal. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, an appeal determination will be rendered not later than the third meeting following the Plan's receipt of your written request for review. If such an extension is necessary, the Plan will provide you with a written (or electronic, as applicable) notice of extension describing the special circumstances and date the appeal determination will be made. The Board of Trustees will notify you in writing (or electronically, as applicable) of the benefit determination no later than five (5) calendar days after the benefit determination is made.

- ***Accidental Death and Dismemberment Insurance/Death Benefit Claims***

  A written (or electronic, as applicable) notice regarding a determination of your appeal will be sent to you within sixty (60) days from the date your written request for an appeal is received by the Plan.

Notice of Adverse Benefit Determination upon Appeal

A written (or electronic, as applicable) notice of the appeal determination must be provided to you that includes:

- The specific reason(s) for the adverse benefit determination upon appeal, including (i) the denial code (if any) applicable to a health benefit claim and its corresponding meaning, (ii) a description of the Plan's standard (if any) that was used in denying the claim, and (iii) a discussion of the decision;

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

- A statement that you are entitled to receive upon request, free access to and copies of documents relevant to the claim;

- A statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;

- An explanation of the external review process, along with any time limits and information about how to initiate a request for an external review regarding the denied internal appeal of a health benefit claim;

- If the denial of a health benefit claim was based on an internal rule, guideline, protocol, standard, or similar criterion a statement must be provided that such rule, guideline, protocol or criteria will be provided free of charge, upon request;

- If the denial of a health benefit claim was based on a medical judgement (Medical Necessity, Experimental or Investigational), a statement must be provided that an explanation regarding the scientific or clinical judgement for the denial will be provided free of charge, upon request; and

- With respect to a health benefit claim, disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with internal claims and appeals and external review processes.

This concludes the appeal process under this Plan.

External Review of Claims

If your initial claim for health care benefits has been denied (i.e., an adverse benefit determination) in whole or in part, and you are dissatisfied with the outcome of the Plan's internal claims and appeals process described earlier, you may (under certain circumstances) be able to seek external review of your claim by an Independent Review Organization ("IRO"). This process provides an independent and unbiased review of eligible claims in compliance with the Affordable Care Act.

Culturally and Linguistically Appropriate Notices

All notices relating to external review sent will contain a notice about the availability of Spanish language services. Assistance with filing a claim for external review in Spanish is available by calling 1-708-449-2123. Notices relating to external review will be provided in Spanish upon request.

SPANISH (Español): Para obtener asistencia en Español, llame al 1-708-449-2123. Claims Eligible For The External Review Process

Post-Service, Pre-Service, Urgent Care, and Concurrent Care Claims, in any dollar amount, are eligible for external review by an IRO if:

- The adverse benefit determination of the claim involves a medical judgment, including but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, denial related to coverage of routine costs in a clinical trial, or a determination that a treatment is Experimental or Investigational. The IRO will determine whether a denial involves a medical judgment.
- The denial is due to a rescission of coverage (i.e., the retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time.

Claims Not Eligible For The External Review Process

The following types of claims are not eligible for the external review process:

- Claims that involve only contractual or legal interpretation without any use of medical judgment.
- A determination that you or your Dependent are not eligible for coverage under the terms of the Plan.
- Claims that are untimely, meaning you did not request review within the four (4) month deadline for requesting external review.
- Claims as to which the Plan's internal claims and appeals procedure has not been exhausted (unless a limited exception applies).
- Claims that relate to benefits other than health care benefits (such as dental or vision benefits that are considered excepted benefits).
- Claims that relate to benefits that the Plan provides through insurance. Claims that relate to benefits provided through insurance are subject to the insurance company's external review process, not this process.

In general, you may only seek external review after you receive a "final" adverse benefit determination under the Plan's internal appeals process. A "final" adverse benefit determination means the Plan has continued to deny your initial claim in whole or part and you have exhausted the Plan's internal claims and appeals process.

Under limited circumstances, you may be able to seek external review before the internal claims and appeals process has been completed:

- If the Plan waives the requirement that you complete its internal claims and appeals process first.
- In an urgent care situation (see "Expedited External Review of an Urgent Care Claim"). Generally, an urgent care situation is one in which your health may be in serious jeopardy or, in the opinion of your health care professional, you may experience pain that cannot be adequately controlled while you wait for a decision on your internal appeal.
- If the Plan has not followed its own internal claims and appeals process and the failure was more than a minor error. In this situation, the internal claims and appeal is "deemed exhausted," and you may proceed to external review. If you think that this situation exists, and the Plan disagrees, you may request that the Plan explain in writing why you are not entitled to seek external review at this time.

External Review of a Standard (Non-Urgent Care) Claim

Your request for external review of a standard (not Urgent Care) claim must be made in writing within four (4) months after you receive notice of an adverse benefit determination.

Because the Plan's internal claims and appeals process generally must be exhausted before external review is available, external review of standard claims will ordinarily only be available after you receive a "final" adverse benefit determination following the exhaustion of the Plan's internal claims and appeals process.

To begin the standard external review process, contact the following:

Fund Administrator
Sheet Metal Workers' Local 73 Welfare Fund
Plan for Retired Members
4530 Roosevelt Road
Hillside, IL 60162
1-708-449-7373
www.sm73funds.org

Preliminary Review of a Standard (Non-Urgent Care) Claim by the Plan

Within five (5) business days of the Plan's receipt of your request for external review of a standard claim, the Plan will complete a preliminary review of the request to determine whether:

- You are/were covered under the Plan at the time the health care item or service is/was requested; or, in the case of a retrospective review, you were covered at the time the health care item or service was provided.
- The adverse benefit determination satisfies the above-stated requirements for a claim eligible for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan; or to a denial that is based on a contractual or legal determination, or a failure to pay premiums causing a retroactive cancellation of coverage.
- You have exhausted the Plan's internal claims and appeals process (or a limited exception allows you to proceed to external review before that process is completed).
- Your request is complete, meaning that you have provided all of the information or materials required to process an external review.

Within one (1) business day of completing its preliminary review, the Plan will notify you in writing whether:

- Your request is complete and eligible for external review.
- Your request is complete but not eligible for external review. (In this situation, the notice will explain why external review is not available, and provide contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272).)
- Your request is incomplete. (In this situation, the notice will describe the information or materials needed to make the request complete. You must provide the necessary information or materials within the four (4) month filing period, or, if later, within forty-eight (48) hours after you receive notification that your request is not complete.)

Review of a Standard (Not Urgent Care) Claim by the IRO

If your request is complete and eligible for external review, the Plan will assign it to an accredited IRO. The Plan has arranged for at least three (3) accredited IROs to provide external review of claims, and it rotates assignments among these IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

Once the claim has been assigned to an IRO, the following procedures apply:

- The IRO will timely notify you in writing that your request is accepted for external review.
- The IRO will explain how you may submit additional information regarding your claim if you wish.

In general, you must provide additional information within ten (10) business days. The IRO is not required to, but may, accept and consider additional information you submit after the ten (10) business day deadline.

- Within five (5) business days after the claim has been assigned to the IRO, the Plan will provide the IRO with the documents and information it considered in making its adverse benefit determination.
- If you submit additional information to the IRO related to your claim, the IRO must forward that information to the Plan within one (1) business day. Upon receipt of any such information (or at any other time), the Plan may reconsider its adverse benefit determination regarding the claim that is the subject of the external review. Any reconsideration by the Plan will not delay the external review. If Plan reverses its determination after it has been assigned to an IRO, the Plan will provide written notice of its decision to you and the IRO within one (1) business day. Upon receipt of such notice, the IRO will terminate its external review.
- The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo, meaning that the IRO is not bound by the Plan's previous internal claims and appeal decisions. However, the IRO must review the Plan's terms to ensure that its decision is not contrary to the terms of the Plan, unless those terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.
- To the extent additional information or materials are available and appropriate, the assigned IRO may consider the additional information including information from your medical records, any recommendations or other information from your treating Health Care Providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).
- In a standard case, the IRO will provide written notice of its final decision to you and the Plan within forty-five (45) days after the IRO receives the request for the external review.

The IRO's decision notice will contain:

- A general description of the reason(s) for the request for external review, including information sufficient to identify the claim, including the date or dates of service, the Health Care Provider, the claim amount (if applicable), and the reason for the previous denial.
- The date that the IRO received the assignment to conduct the external review and the date of the IRO decision.
- References to the evidence or documents, including the specific coverage provisions and evidence-based standards, considered in reaching its decision.
- A discussion of the principal reason(s) for the decision, including the rationale for the decision and any evidence-based standards relied upon.
- A statement that the IRO's decision is binding on you and the Plan, except to the extent that other remedies may be available to you or the Plan under applicable state or federal law.
- A statement that judicial review may be available to you.

- A statement regarding assistance that may be available to you from an applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act.

U.S. Department of Labor
Employee Benefits Security Administration
200 Constitution Ave., NW
Washington, DC 20210
(866) 4-USA-DOL ((866) 487-2365)
http://www.dol.gov/ebsa/consumer_info_health.html

Expedited External Review of an Urgent Care Claim

You may request an expedited external review in the following situations if:

- You receive an adverse benefit determination regarding your initial claim that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal.
- You receive a "final" adverse benefit determination after exhausting the Plan's internal appeals procedure that (i) involves a medical condition for which the timeframe for completion of an standard external review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function; or (ii) concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, and you have not yet been discharged from a facility.

To begin a request for expedited external review, contact the following:

Fund Administrator
Sheet Metal Workers' Local 73 Welfare Fund
Plan for Retired Members
4530 Roosevelt Road
Hillside, IL 60162
1-708-449-7373
www.sm73funds.org

Preliminary Review of an Urgent Care Claim by the Plan

Immediately upon receipt of a request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described above for the standard claim external review process). The Plan will defer to your attending health care professional's determination that a claim constitutes "urgent care." The Plan will immediately notify you (e.g., telephonically, via fax) whether your request for review meets the requirements for expedited review, and if not, it will provide or seek the information described above for the standard claim external review process.

Review of an Urgent Care Claim by the IRO

Upon a determination that a request is complete and eligible for an expedited external review following the preliminary review, the Plan will assign an accredited IRO. The Plan has arranged for at least three (3) accredited IROs to provide external review of claims, and rotates assignments among those IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will

support the denial of claims.

The Plan will expeditiously provide or transmit to the IRO all necessary documents and information that it considered in making its internal adverse benefit determination.

The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review. In reaching a decision, the IRO must review the claim *de novo* meaning that it is not bound by any previous decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO decision must not be contrary to the terms of the plan, unless the terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above for the standard claim external review process, as expeditiously as your medical condition or circumstances require, but not more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If notice of the IRO decision is not provided to you in writing, the IRO must provide written confirmation of the decision to you and the Plan within forty-eight (48) hours after it is made.

What Happens after the IRO Decision is made?

If the IRO's final external review decision reverses the Plan's internal adverse benefit determination, upon the Plan's receipt of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

If the final external review upholds the Plan's internal adverse benefit determination, the Plan will continue not to provide coverage or payment for the reviewed claim.

If you are dissatisfied with the external review determination, you may seek judicial review to the extent permitted under ERISA section 502.

Authorized Representative

The Plan recognizes an authorized representative as any person at least 18 years old whom you have designated in writing as the person who can act on your behalf to file an initial claim and appeal an adverse benefit determination under the Plan. An authorized representative under the Plan also includes a health care professional. You do not need to designate in writing that the health care professional is your authorized representative if that health care professional is part of the claim appeal. A Health Care Provider with knowledge of your medical condition may act as your authorized representative in connection with an Urgent Care Claim without filing a written statement with the Plan.

The Plan requires you to provide a written statement declaring your designation of an authorized representative along with the representative's name, address, phone number, and email address. To designate an authorized representative, you must submit a completed authorized representative form (available from the Fund Administrator).

If you are unable to provide a written statement, the Plan will require written proof that the proposed authorized representative has the power of attorney for health care purposes (*e.g.,* notarized power of

attorney for health care purposes, court order of guardianship/conservatorship or is your legal spouse, parent, grandparent, or child over the age of 18).

Once the Plan receives an authorized representative form all future claims and appeals-related correspondence will be routed to the authorized representative rather than to you. The Plan will honor the designated authorized representative for one (1) year before requiring a new authorization/until the designation is revoked, or as mandated by a court order. You may revoke a designated authorized representative status by submitting a completed change of authorized representative form available from and to be returned to the Fund Administrator.

The Plan reserves the right to withhold information from a person who claims to be your authorized representative if there is suspicion about the qualifications of that individual.

Limitation on When a Lawsuit May be Started

You or any other claimant may not start a lawsuit or other legal action to obtain Plan benefits, including proceedings before administrative agencies, until after all administrative procedures have been exhausted (including this Plan's internal claims and appeal procedures described in this section) for every issue deemed relevant by the claimant, or until ninety (90) days have elapsed since you filed a request for appeal review if you have not received a final decision or notice that an additional sixty (60) days will be necessary to reach a final decision. With respect to health claims, the law also permits you to pursue your remedies under section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them properly. For post-service claims, please be advised that your appeal will be decided at the second quarterly Board meeting, or if the Plan received the appeal within thirty (30) days of a Board meeting, the third meeting from receipt.

In addition, with respect to health care claims, you are not required to exhaust external review before seeking judicial remedy.

The Plan has a two (2) year statute of limitations. Notwithstanding any other state or federal law, any and all legal actions against the Plan or its Trustees must be filed within two (2) years of the action or inaction complained of. This includes but is not limited to actions to recover benefits that must be filed within two (2) years of the final decision on your claim. The situs of the Plan is in Cook County, Illinois. Legal actions must be brought in the appropriate state or federal court located in Cook County, Illinois.

Assignment of Benefits

You and your Eligible Dependents' right to receive benefit payments, appeal a claim, or bring a cause of action against the Plan is personal to you or your Eligible Dependents. Any claim or rights under the Plan, which includes but is not limited to any right to appeal a claim under the procedure set forth in the Plan document, any right to bring a cause of action against the Plan in any forum, or any right to receive benefits or benefit payments from the Plan, is not assignable or transferrable in whole or in part to any other person, Provider, or other entity at any time. Any assignment or transfer of a claim or other rights to receive benefit payments is void unless you or your Eligible Dependents receive written consent from the Board of Trustees. Nothing in this clause will prevent the Plan from paying a Provider or similar entity directly and any such payment shall not constitute a waiver of this anti-assignment clause. In addition, the Trustees' consent or lack thereof to the assignment or transfer of benefits does not affect your or your Eligible Dependents' eligibility for benefits under the Plan.

Elimination of Conflict of Interest

With respect to health claims, to ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators, medical professionals and vocational experts) act independently and impartially, decisions related to those persons' employment status (such as decisions related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

Facility of Payment

If the Board of Trustees or its designee determines that you cannot submit a claim or prove that you or your covered Dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan benefits directly to the health care professional(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Board of Trustees, appropriate Claims Administrator nor any other designee of the Plan will be required to see to the application of the money so paid.

Payment of Benefits

Benefits are payable only if you submit timely and adequate proof of your claim.

Benefits are payable to the claimant whose Injury or Sickness is the basis for a claim under the Plan, except that in the case of the Retiree's death, any applicable Death Benefits are paid in accordance with the Beneficiary provisions for Accidental Death and Dismemberment Benefits. The Plan will generally pay network Hospitals, Physicians, or any other network Provider directly.

If any individual is, in the opinion of the Trustees, legally incapable of giving a valid receipt for any payment due and no guardian has been appointed for that individual, the Trustees may, at their discretion, make such payment to the person or persons who, in the opinion of the Trustees, have assumed the care and principal support of such individual. If the individual should die before all amounts due and payable have been paid, the Trustees may, at their option, make such payment to the executor, administrator or personal representative of his or her estate or to his surviving spouse, parent, Child or Children, or to any other person or persons who are entitled to such payment, in the Trustees' opinion.

Any payments made by the Trustees in accordance with these provisions will fully discharge the liability of the Trustees to the extent of such payment.

Wrongful or Erroneous Benefit Payments

If the Plan erroneously pays benefits, then the Plan will be entitled to:

- A refund from you or your healthcare Provider of the difference between the amount paid by the Plan for those expenses and the amount of Plan benefits that should have been paid by the Plan for those expenses based on the actual facts, or
- An offset of future benefits from you and/or your Dependents to recover such expenses, and
- If the erroneous payment was due in whole or in part to misstatements, omissions, fraud or wrongful acts, the Plan is entitled to recovery from you or the responsible Provider of the Plan's attorney's

fees, costs and expenses incurred in recovering monies that were erroneously paid because of such misrepresentation or falsification, together with the greater of the Plan's actual earnings or interest thereon.

Coordination of Benefits

If you or your Dependent is covered under more than one (1) plan of group benefits, there may be instances where coverage is duplicated – two (2) plans pay benefits for the same expenses. For that reason, a coordination of benefits provision has been adopted to coordinate the benefits payable as described in this booklet with similar benefits payable under other plans.

Under the Coordination of Benefits (COB) provision for benefits other than dental services, if you or any of your Dependents are also covered under any other group plan, the total payments you will receive from all such programs combined will not amount to more than 100% of Medically Necessary Expenses up to the Reasonable and Customary amount.

The Plan coordinates benefits with other plans under which you and your Dependents may be covered for benefits so that reimbursement from both plans never exceeds 100% of your Reasonable and Customary expenses.

For COB purposes, plan means any program, other than individual insurance, that provides benefits or services for medical care or treatment through group insurance coverage or any other pre-payment or service type plan.

Determining Which Plan Pays First

If you or your Dependents are covered by another plan or plans, the benefits under this Fund and the other plan(s) will be coordinated. This means one (1) plan pays its full benefits first, then the other plan or plans pay.

1. The primary plan (which is the plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this provision.
2. The secondary plan (which is the plan that pays benefits after the primary plan) will limit the benefits it pays so that the sum of its benefits and all other benefits paid by the primary plan will not exceed the greater of:
    a) 100% of total covered expenses, or
    b) The amount of benefits it would have paid had it been the primary plan.

If you or your Dependents are eligible under another plan, there are a few simple rules that determine the order in which benefits are paid.

1. When another plan does not have a COB provision, that plan must determine benefits first.
2. When another plan does have a COB provision, the first of the following rules that applies governs:
    a) If a plan covers the claimant as an active Employee, then that plan will pay its benefits first.
    b) For an Eligible Dependent child whose parents are not divorced or separated, the plan of the parent whose birthday (month and day) is earlier in the calendar year will pay first. If both parents' birthdays are the same day, the last rule will apply.

c) For an Eligible Dependent child whose parents are divorced or separated, the following rules apply:

i) A plan that covers a child as a Dependent of a parent who by court decree must provide health coverage will pay first.

ii) When there is no court decree that requires a parent to provide health coverage for a Dependent child, the following rules will apply:

- When the parent who has custody of the child has not married, that parent's plan will pay first and the non-custodial parent's plan will pay second.
- When the parent who has custody of the child has remarried, benefits will be determined by that parent's plan first, by the stepparent's plan second, and by the non-custodial parent's plan third.

The birthday rule provides that the plan of the parent with the birthday that occurs earlier in the year pays first.

The birthday comparison is by month and day only and not by year. For example, the plan of a parent who is older but who has a December birthday will be secondary to the parent who may be younger but who has a birthday earlier in the year.

d) If none of the above rules apply, the plan that has covered the claimant for the longest period will pay its benefits first, except:

i) When one (1) plan covers the claimant as a laid-off or retired Employee (or a Dependent of such an Employee), and the other plan includes a COB rule for laid-off or retired Employees, the plan that covers the claimant as other than a laid-off or retired Employee (or a Dependent of such an Employee) will pay first,

ii) If both plans cover the claimant as a laid-off or a retired Employee (or a Dependent of such Employee) the plan that covered the Employee for the longest period will pay first.

If part of a plan coordinates benefits and a part does not, each part will be treated like a separate plan. The Plan will always pay primary to Medicaid.

Notwithstanding any provision to the contrary, if an Eligible Dependent is covered by another group health plan that reduces or eliminates its benefits when a Dependent is covered by another group health plan, or if the other group health plan has COB provisions that differ from those of this Plan, this Plan will only pay the amount of benefits that would be payable if the other group health plan had the same coordination of benefit provisions as this Plan.

Information Required for Coordination of Benefits

For the purposes of Coordination of Benefits, the Fund Office:

1. May release to or obtain from any other plan or other organization or person any claim information, and any person claiming benefits under the Fund must furnish any information that the Fund may require to coordinate benefits, in accordance with the federal law governing privacy and security of your medical records,
2. Has the right, if an overpayment is made, to recover such overpayment from any other person or any other plan or organization, and
3. Has the right to pay to any other plan or organization an amount it will determine to be warranted, if payments that should have been made by the Fund have been made by such organization.

WARNING

If you or your Dependents file a claim with the Welfare Fund Office and fail to disclose relevant information concerning your coverage by another plan or other matters relating to coordination of benefits, the Welfare Fund has the right to recover any and all overpayments directly from you, your Dependents, your insurance company or any other person or organization. The Fund also has the right to withhold benefits from you or your Dependents until such amounts are recouped, together with interest or lost earnings, attorneys' fees, and costs.

How Medicare Affects Medical Benefits Under the Plan

About Medicare

Medicare is a four (4) part program. The first part is officially called "Hospital Insurance Benefits for the Aged and Disabled," and this part is commonly referred to as Part A of Medicare. The second part is officially called "Supplementary Medical Insurance Benefits for the Aged and Disabled," and this part is commonly referred to as Part B of Medicare. The third part is Medicare Advantage or Medicare Part C and generally involves coverage under one of the Medicare HMO (Health Maintenance Organization) offerings for Participants who live in a geographic area served by a Medicare HMO and who choose to be covered by a Medicare HMO. Medicare Part D provides Prescription Drug coverage. Part A of Medicare primarily covers Hospital benefits, although other benefits are also provided. Part B of Medicare primarily covers Physician's services, although it, too, covers a number of other items and services. Part C covers both Hospital and Physician services. Part D covers Prescription Drug expenses.

Typically, a person becomes eligible for Medicare upon reaching age 65. Under certain circumstances, a person may become eligible for Medicare before age 65 if the person is a disabled worker, disabled widow, or Dependent widower or has chronic renal disease.

When you reach age 65, you are eligible to apply for all parts of Medicare coverage. Part A of Medicare is ordinarily free, and premiums are required for the other Parts of Medicare. If you are not yet receiving Social Security benefits, you must pay any required premium to the Social Security Administration. If you are receiving Social Security benefits, you will have the premium deducted from your monthly Social Security benefit check.

Coordination of Your Plan Benefits with Medicare

The Plan coordinates benefits with Medicare.

In general, Medicare is the primary plan responsible for paying benefits for Plan participants who are eligible for Medicare Parts A and B, or Part C. If you are eligible for Medicare Parts A, B, or C, the Plan will not pay benefits covered by Medicare, regardless of whether you or your dependents actually enroll in Medicare Parts A, B, or C. Additional benefits that are not covered by Medicare are offered by this Plan to eligible Retirees and their Eligible Dependents. For those additional benefits, this Plan is primary.

If you are enrolled in Medicare Part A and Part B, you may be eligible to participate in the Sheet Metal Workers' Local 73 Supplemental Wraparound Insurance (SMW+).

If you are covered by this Plan as a Retiree and you are eligible to enroll in Medicare Part D, you are not required to enroll in Medicare Part D. The Plan will pay your Prescription Drug Benefits without taking eligibility for Medicare Part D into account. However, if you are eligible for, and enroll in Medicare Part D, you will lose your Prescription Drug benefits provided by the Plan.

Reimbursement Policies and Procedures

If the Welfare Fund pays benefits to or for you, your Dependent, your estate or your Dependent's estate as a result of an accident, Injury, or Sickness for which any third party is or may be liable, the Fund has a right to be reimbursed from any settlement, judgment, insurance proceeds, no-fault automobile insurance payments, or other recovery for any and all benefits paid in connection with such Injury and Sickness up to the amount of recovery.

In addition, the Fund will have a first equitable lien and constructive trust upon any such recovery in the amount of all benefits paid up to the amount of your recovery, regardless of how the recovery is allocated or structured. You must hold any such recovery in constructive trust for the benefit of the Fund. The Fund's right of reimbursement is from the first dollar you receive. The enforcement of this right does not require that you be made whole or otherwise receive your full claim from the third party, unless the Fund agrees in writing to a reduction of its claim.

You, your Dependent or estate must sign the Fund's written Reimbursement Agreement Form acknowledging the Fund's rights under this provision. The Fund may withhold benefits until such agreement is signed. If the Fund pays a claim in the absence of a Reimbursement Agreement, or pays a claim in error, that payment will not waive, compromise, diminish, release, or prejudice any right the Plan has to reimbursement or a lien.

You, your Dependent or estate must immediately inform the Fund in writing of any legal action or any recovery that arises subsequent to the payment of benefits by the Fund. You, your Dependent or estate must cooperate fully with the Fund in connection with the exercise of its rights under this provision and must do nothing to prejudice such rights.

> You must avoid doing anything that would prejudice the Plan's right of reimbursement and repayment. In the event there is a claim against a third party, you must promptly advise the Fund.

The Common Fund Doctrine will not apply to any recovery, and the Fund will not pay fees or costs incurred in connection with any sum recovered unless the Fund has agreed in writing to pay a portion of those fees or costs. The amount recoverable by the Fund includes any and all amounts paid by the Plan in relation to your Sickness or Injury, all administrative fees and expenses related to the claim (such as PPO access fees) and the Fund's costs and reasonable attorneys' fees (even for appeals), regardless of the amount of your actual recovery. The Plan's reimbursement and lien rights apply, without regard to State law limitations on liens against workers' compensation recoveries.

The Fund may, at its option, initiate legal action to secure and protect its rights under this provision.

In the event that reimbursement is not made as provided above, the Fund has the right to withhold any future benefits that you, your Dependent or estate may be entitled to receive until the Fund has been reimbursed. In the event that you, your Dependent or estate fails to timely inform the Fund of any recovery, the Fund will have a right of reimbursement from you, your Dependent or estate for any and all benefits paid and for costs of suit, including payment of reasonable attorney fees, regardless of the amount of the actual recovery. The Fund Office may also suspend your benefits after giving you a thirty (30) day notice of suspension, if the Fund Office learns that you have received a recovery without making reimbursement to the Fund and if you are not engaged in good faith negotiations to settle the Fund's right to reimbursement.

Benefits to Which Reimbursement Applies

The Plan's Reimbursement provisions apply to the following benefits paid by the Plan: medical, dental, vision, prescription drug, and hearing aid benefits. The Plan's Reimbursement provisions do not apply to Death Benefits or Accidental Death and Dismemberment Benefits provided by the Plan.

Situations Where Reimbursement Provisions May Apply

The Plan has the right of reimbursement for benefits that it pays as a result of an Injury, accident or Sickness for which any third party may be liable. This can include auto accidents, workers' compensation injuries, personal injuries, medical malpractice injuries, injuries from fights or beatings, poisonings or toxic injuries, or a case of slip and fall.

Reimbursement Procedures

The Board of Trustees has established reimbursement procedures for the Welfare Fund that they may change from time to time. The Fund Office will follow the reimbursement procedures. The Board of Trustees of the Welfare Fund has delegated full discretionary authority to the Benefits Appeals Committee of the Board of Trustees to collect and settle Reimbursement claims.

If you sign a Reimbursement Agreement, the Fund may reduce its share of the recovery for its proportionate share of attorneys' fees and its share of your out-of-pocket expenses. The Trustees or Appeals Committee have the discretion to settle reimbursement claims or liens. Other guidelines apply to the recovery available by the Fund. Contact the Fund Office for more details.

Refusal to Cooperate in Reimbursement Claims

The Fund Office may suspend benefit payments for your claims related to third-party Injury or illness until you return a signed Reimbursement Agreement to the Fund Office. The Fund Office may also suspend benefits or withhold future benefit payments if you refuse to provide information to the Fund Office or otherwise refuse to cooperate with the Fund Office.

The Fund Office may suspend all Welfare Benefit payments or withhold future benefit payments, regardless of the nature or source, from you and/or your Dependents if you receive a recovery and you either fail to report that recovery to the Fund Office, refuse to reimburse the Fund Office, or reject a settlement in accordance with the Plan's Reimbursement guidelines. Benefits should recommence after the total amount of payments withheld equals the amount of recovery due the Fund under the Fund's Reimbursement policies and procedures.

Important Information About the Plan

The following information is provided to help a member identify this Fund and the people who are involved in its operation.

Name of Plan. This Plan is known as the Sheet Metal Workers' Local 73 Welfare Fund Plan for Retired Members.

Board of Trustees. A Board of Trustees is responsible for the operation of this Fund. The Board of Trustees consists of equal representation of Employer and Union representatives, selected by the Employers and the Union that have entered into collective bargaining agreements that relate to this Fund. If you wish to contact the Board of Trustees, you may use the following address and phone number:

Sheet Metal Workers' Local 73 Welfare Fund
4530 Roosevelt Road
Hillside, Illinois 60162
1-708-449-7373

The Trustees of this Fund are:

Union Trustees	Employer Trustees
Mr. Ray Suggs Sheet Metal Workers' Local 73 Welfare Fund 4550 Roosevelt Road Hillside, Illinois 60162	Mr. William J. Beukema, Jr. SMACNA Greater Chicago 1415 W. 22nd Street, Suite 1200 Oak Brook, IL 60523-8433
Mr. Daniel Ahern Sheet Metal Workers' Local 73 Welfare Fund 4550 Roosevelt Road Hillside, Illinois 60162	Mr. James S. Billard SMACNA Greater Chicago 1415 W. 22nd Street, Suite 1200 Oak Brook, IL 60523-8433
Mr. Michael A. Vittorio Sheet Metal Workers' Local 73 Welfare Fund 4550 Roosevelt Road Hillside, Illinois 60162	Mr. Tony Adolfs SMACNA Greater Chicago 1415 W. 22nd Street, Suite 1200 Oak Brook, IL 60523-8433

P**lan Sponsor and Administrator**. The Board of Trustees is both the Plan Sponsor and the Plan Administrator for the Plan. This means that the Board of Trustees is responsible for the operation and administration of the Plan. The Plan Administrator has broad discretion to determine eligibility for benefits and to interpret the language of the Plan. The Plan Administrator's decisions should receive judicial deference to the extent that they do not constitute an abuse of discretion. The Board has delegated the day-to-day administrative responsibilities to the Fund Administrator, Patrick Ludvigsen, who can be contacted at the Fund Office.

Identification Numbers. The number assigned to the Board of Trustees by the Internal Revenue Service is 36-2145881. The number assigned to this Fund by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501.

Agent for Service of Legal Process. Patrick Ludvigsen, Fund Administrator, 4530 Roosevelt Road, Hillside, Illinois 60162, is the Fund's agent for service for legal process. Accordingly, if legal disputes

involving the Fund arise, any legal documents may be served upon him at his address or any of the Trustees at the Fund Office address.

Source of Contributions. Contributions to the Fund are made by Employers in accordance with their collective bargaining agreement with Sheet Metal Workers' International Association Local 73 of Chicago, Cook and Lake Counties, Illinois AFL-CIO or participation agreement with the Welfare Fund. However, in specific situations, self-payments are required to be made pursuant to the provisions of the Fund. The Employer's obligation to contribute to the Plan continues until the Employer formally withdraws from participation.

The Fund Office will provide you, upon written request, information as to whether your Employer is participating in this Plan and the Employer's address.

Trust Fund. All assets are held in trust by the Board of Trustees for the purpose of providing benefits to you and your Dependents as Plan Participants and defraying reasonable administrative expenses. The Fund's assets and reserves are presently invested by the Board of Trustees.

Plan Assets. All benefits payable under the terms of the Plan are Plan assets until they are actually paid in accordance with the terms of the Plan. Any check issued to pay benefits under the Plan shall be scheduled to expire (90) days after the date of its issuance. Once benefits become payable under the terms of the Plan, Participants will be able to claim payment of their benefits until the one (1) year anniversary from the date on which they became payable. Following the one (1) year anniversary of becoming payable, unclaimed benefits shall be forever forfeited and may be used to pay other benefits or Plan expenses.

Benefit Administration. Prescription Drug Benefits are administered by Express Scripts, Inc. Medical benefits are administered by Blue Cross Blue Shield of Illinois. Dental Benefits are administered by Delta Dental of Illinois. Vision Benefits are administered by EyeMed Vision Care. All benefits are provided on a self-funded basis directly from the Fund.

Plan Year. The records of the Plan are kept separately for each Plan Year. The Plan Year begins July 1 and ends on June 30.

Type of Plan. This Plan is maintained for the purpose of providing health, prescription drug, dental, wellness, hearing, vision, death and accidental death and dismemberment benefits in the event of Sickness, accident or death. The Plan benefits are shown in the applicable Schedule of Benefits on page 4 and 7 of this booklet.

Collective Bargaining Agreement. The Fund is maintained in accordance with a collective bargaining agreement between the contributing Employers and Sheet Metal Workers' International Association Local 73 of Chicago, Cook and Lake Counties, Illinois AFL-CIO. You may obtain a copy of the agreement by written request to the Board of Trustees. A reasonable charge may be imposed for the copy. In addition, a copy of the agreement may be examined without charge at the Fund Office or at the principal place of business of your Employer.

No Employment Guarantee. Your coverage by the Fund does not constitute a guarantee of your continued employment.

Plan Documents. This booklet serves as both the Plan Document and Summary Plan Description. This booklet replaces any prior Summary Plan Description booklets, Plan Documents, and other Plan related documents you may have previously received.

Other important documents are the Agreement and Declaration of Trust and the collective bargaining agreements.

Amendment or Termination of the Plan. While the Trustees fully intend to continue the Plan, they reserve the right and they have the broad discretion to alter or discontinue the Plan. The provisions of the Plan may be amended from time to time in accordance with the Trust Agreement. Amendments may include increases, modifications, reductions or the elimination, in whole or in part, of certain benefits. The Board of Trustees has the right to initiate, increase and/or decrease self-payments.

The Plan may be terminated under circumstances allowed by ERISA and the terms of the governing Trust Agreement. In addition, the Trustees reserve the right to initiate, increase and/or decrease self-payments for Plan coverage. If the Trustees amend or terminate the Plan, they will notify you in writing of the changes that are made to your coverage.

If the Plan is terminated, benefits for covered expenses incurred before the termination date fixed by the Trustees will be paid to eligible Participants, as long as the Plan's assets are more than the Plan's liabilities. If there are any excess assets remaining after the payment of all Plan liabilities, those excess assets will be used for purposes determined by the Trustees in accordance with the provisions of the Trust Agreement.

The Trustees, as Plan Administrator, have broad discretion to amend or terminate the Plan. If the decisions of the Plan Administrator or Fund Administrator are challenged in court, it is the intention of the Fund that the Plan Administrator or Fund Administrator's decisions, as applicable, be accorded judicial deference to the extent that they do not constitute an abuse of discretion.

No Vested Right to Plan Benefits. Your coverage by the Plan does not confer any right to continue benefits. The welfare benefits provided by the Plan are not vested benefits.

Statement of Rights Under the Employee Retirement Income Security Act (ERISA)

As a Participant in the Sheet Metal Workers' International Association Local Union No. 73 Welfare Fund for Retired Members, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all Plan Participants are entitled to the following rights.

Receive Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Fund Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan. These include insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request to the Fund Administrator, copies of documents governing the operation of the Plan. These include insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Fund Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Fund Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You also have the right to:

- Continue healthcare coverage for yourself, spouse, or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within (30) days, you may file suit in a federal court. In such a case, the court may require the Fund Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Fund Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

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

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (EBSA). For single copies of publications, contact the EBSA Brochure Request Line at 866-444-3272 or contact the EBSA field office nearest you.

You may also find answers to your Plan questions at the website of the EBSA at http://www.dol.gov/ebsa/. A list of EBSA Field Offices is located at http://www.dol.gov/ ebsa/aboutebsa.

Your Privacy Rights Under the Plan

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health plans protect the confidentiality and electronic security of your protected health information (PHI). You may find a complete description of your rights under HIPAA in the Plan's Privacy Notice that describes the Plan's privacy policies and procedures and outlines your rights under the privacy rules and regulations.

The Plan will distribute its Privacy Notice or a reminder that the notice is available from the Fund Office periodically, as required by the privacy rules, and when substantial changes are made in the Plan's privacy policies and procedures.

This Plan and the Plan Sponsor will not use or further disclose your protected health information except as necessary for treatment, payment, health plan operations and Plan administration or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose your protected health information for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor.

Protected Health Information (PHI) includes all information related to your past, present or future physical or mental health condition or payment for healthcare. PHI also includes information maintained by the Plan in oral, written or electronic form.

The Plan also hires professionals and other companies to assist it in providing healthcare benefits. The Plan has required these entities, called "Business Associates" to observe HIPAA's privacy and security rules. In some cases, you may receive a separate notice from one of the Plan's Business Associates. It will describe your rights with respect to benefits provided by that company.

Your rights under HIPAA with respect to your protected health information include the right to:

1. See and copy your health information;
2. Receive an accounting of certain disclosures of your health information;
3. Amend your health information under certain circumstances; and
4. File a complaint with the Plan or with the Secretary of Health and Human Services if you believe your rights under HIPAA have been violated.

The Plan Sponsor will:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the group health plan;

2. Ensure that the adequate separation, specific to electronic PHI, is supported by reasonable and appropriate security measures;

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

4. Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

If you need a copy of the Privacy Notice, please contact the Fund Office.

Ambulatory Surgical Facility means a facility (other than a Hospital), that:

1. Has the primary function of providing surgical procedures on an ambulatory basis, and
2. Is duly licensed by the appropriate state and local authority to provide such services and, if the facility is an in-network facility, it is approved by Blue Cross Blue Shield of Illinois.

Behavioral Health Practitioner means a psychiatrist, mental health counselor, Substance Abuse counselor or social worker with a master's degree or higher. The Provider must be legally licensed or authorized to practice or provide service, care or treatment for such conditions under State law, and act within the scope of that license.

Beneficiary means a person you designate to receive your life insurance benefits.

Child or Children has the meaning provided in the definition of Eligible Dependent, as defined in the *Eligibility* section beginning on page 12.

Contracted Medical Claim Review Providers mean the third-party reviewers that provide medical review of claims for services that require pre-approval that is arranged through the Fund Office. Such reviewers determine whether services and the proposed duration of services is Medically Necessary.

Covered Employment means work for which a contributing Employer is required to make contributions to the Welfare Fund on behalf of Employees pursuant to the terms of a collective bargaining agreement with Sheet Metal Workers' Local Union No. 73 or participation agreement with the Fund.

Dental Hygienist means a person who is duly licensed as a Dental Hygienist currently practicing within the scope of his or her license, performing services under the direction of a licensed Dentist, and must not be the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Dental Treatment Plan is a Dentist's report, on a form satisfactory to the Plan that:

1. Itemizes the dental services recommended by the Dentist for the necessary and customary dental care of an eligible person,
2. Shows the charge for each dental service, and
3. Is accompanied by appropriate diagnostic materials as required by the Plan.

Dentist is a duly licensed Dentist (D.D.S. or D.D.M.) currently practicing within the scope of his or her license and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Dependent has the meaning provided in the definition of Eligible Dependent, and as further described in the *Eligibility* section beginning on page 12.

Diagnostic Services means tests rendered for the diagnosis of symptoms to evaluate or determine the progress of a condition, disease or Injury. Such tests include but are not limited to x-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests and electromyograms.

Durable Medical Equipment means equipment that meets all of the following requirements (see the list in Appendix A):

1. Can withstand repeated use (*i.e.*, could normally be rented and used by successive patients),
2. Is primarily and customarily used to serve a medical purpose,
3. Generally is not useful to a person in the absence of Sickness or Injury,
4. Is appropriate for use in the home, and
5. Is used solely for the care and treatment of the patient.

The Trustees have the authority and discretion to determine what constitutes Durable Medical Equipment and covered supplies for items not listed in Appendix A, and when to rent, lease or purchase the equipment.

Eligible Dependent has the meaning provided in the *Eligibility for Non-Medicare Eligible Retirees* section on page 12.

Emergency Services means with respect to an Emergency Medical Condition (defined below), a medical screening examination within the emergency department of a Hospital, including ancillary services routinely available to 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 at the Hospital to stabilize the patient.

1. The term "to stabilize" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an Emergency Medical Condition, to deliver a newborn child (including the placenta).

2. The term Emergency Medical Condition means a medical condition 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 medical attention to result in serious jeopardy to the health of the individual (or for a pregnant woman, the health of the woman or her unborn child), serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

Employee means an individual, employed by an Employer, on whose behalf the Employer, pursuant to a collective bargaining agreement with the Union or participation agreement with the Fund, is required to make contributions to the Trust Fund.

Employee also means a full-time teacher in the Local 73 Sheet Metal Workers' Apprenticeship Program and the Eligible Dependents of that teacher, provided the appropriate contributions are made to the Plan on behalf of the Employee.

Sole Proprietors, or partners in a partnership or similar business entity required to make Employer Contributions to the Plan are not considered Employees under the Plan, unless they meet the definition of Employee in the prior two paragraphs.

Employer means an Employer that has or may hereafter have a collective bargaining agreement in effect with Sheet Metal Workers' International Association Local No. 73 requiring periodic payments to the Sheet Metal Workers' Local 73 Welfare Fund for Active Members for the purpose of providing and maintaining group insurance for the benefit of its Employees.

The term Employer also includes any other Employer that, with the consent of the Trustees, enters into a participation agreement with the Fund, makes payments or contributions to the Welfare Fund and adopts and agrees to be bound by the terms and provisions of the Sheet Metal Workers' Local 73 Welfare Fund Trust Agreement and any amendments and modifications thereof.

Experimental or ***Investigative*** means drugs, services, supplies and procedures that require approval by an agency of the U.S. Government that has not yet been received. Experimental treatments, services and supplies are also those that have been principally confined to laboratory or research settings or have progressed to limited human application but lack wide recognition as proven and effective in clinical medicine. The Trustees have the discretionary authority to determine whether a treatment, service or supply is Experimental or Investigative. The fact that a Physician has prescribed, ordered, recommended or approved the treatment, service or supply does not in itself make it eligible for payment.

Genetic Test means an analysis of human DNA, RNA, chromosomes, proteins or metabolites that detects genotypes, mutations or chromosomal changes.

Health Care Providers, which include Physicians and Surgeons; as well as include, but not limited to the following: Chiropractor, Audiologist, Anesthetist, Clinical Social Worker, Emergency Medical Technician, Independent Laboratory, Certified Nurse Midwife, Licensed Practical Nurse, Registered Nurse, Nurse Practitioner, Clinical Nurse Specialist, Pharmacist, Physical Therapist, Respiratory Therapist, Speech Technician/Therapist (Language Pathologist), Physician Assistant, Surgical Assistant, Nurse Assistant, Licensed Vocational Nurse, Psychiatric Mental Health Nurse, and Registered Surgical Technologist, and any other health care provider who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Hospital public or private facility or institution, licensed and operating according to law that:

1. Provides care and treatment of Physicians and Nurses on a twenty-four (24)-hour basis for Sickness or Injury through the medical, surgical, and diagnostic facilities on its premises;
2. May include facilities for treatment of Mental and Nervous Disorders or Behavioral Health Disorders that are licensed and operated according to law;
3. May include facilities for acute care, sub-acute care, and specialty Hospitals; and
4. May include any portion of a Hospital used as an Ambulatory Surgical Facility, Birth (or Birthing) Center, Hospice, Skilled Nursing Facility, or Subacute Care Facility.

A residential treatment facility or place for rest, custodial care, or place for care of the aged will not be regarded as a Hospital for any purpose related to this Plan.

Injury means a bodily Injury that requires treatment by a Physician, and that results in a loss that is independent of Sickness and other causes.

Inpatient means that you are a registered bed patient and are treated as such in a Hospital, Skilled Nursing Facility, inpatient rehabilitation facility, or alternate facility.

Medically Necessary means that there is a proven need for treatment intervention to improve or preserve the health of the patient. To be considered Medically Necessary, the service, supply or treatment must:

1. Be ordered by a Physician for diagnosis or treatment.
2. Be consistent with the diagnosis or treatment.

3. Be essential for the diagnosis or treatment of the Injury or Sickness for which it is prescribed or performed.
4. Meet generally accepted standards of medical practice.
5. Not be of a research, experimental, or educational nature.
6. Not involve repeated tests.

THE FACT THAT A PHYSICIAN MAY PRESCRIBE, ORDER, RECOMMEND OR APPROVE A TREATMENT, SERVICE OR SUPPLY DOES NOT, OF ITSELF, MAKE THE TREATMENT, SERVICE OR SUPPLY MEDICALLY NECESSARY OR MAKE THE EXPENSE A COVERED CHARGE.

Mental or Nervous Disorder or Behavioral Health Disorder means a neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind, as defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or as identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Non-Physician Providers, some of whose services are excluded from Plan coverage include, but are not limited to, the following: Nurse Assistant, Licensed Vocational Nurse, Psychiatric Mental Health Nurse, and Registered Surgical Technologist.

Non-Plan Skilled Nursing Facility means a Skilled Nursing Facility that does not have an agreement with Blue Cross Blue Shield of Illinois but has been certified in accordance with guidelines established by Medicare. No benefits under the Plan are provided for services received in a Non-Plan Skilled Nursing Facility.

Call or write the Fund Office before admission to a Skilled Nursing Facility to verify that the facility is a Plan Skilled Nursing Facility.

Non-PPO Hospital means a Hospital that is not included in the Blue Cross Blue Shield of Illinois PPO Network at the time services are rendered.

Non-PPO Physician means a Physician who is not included in the Blue Cross Blue Shield of Illinois PPO Network at the time services are rendered.

Outpatient means that you or your Dependent is receiving treatment while not an Inpatient.

Participant means either an Employee or the Employee's Dependent who has met the eligibility requirements to participate in the Plan and is enrolled in Plan coverage.

Physician and/or Surgeon means any individual licensed to practice medicine and perform general surgery (MD) in the State where the license is given, and a Doctor of Osteopathy (DO) and Chiropractor (DC) licensed to practice medicine in the State where the license is given, and who acts within the scope of such license, and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Plan Approved Dialysis Facility means a facility (other than a Hospital) that:

1. Has the primary function of treatment and/or provision of maintenance and/or training dialysis on an ambulatory basis for renal-dialysis patients,
2. Is duly licensed by the appropriate governmental authority to provide such services, and
3. Is approved by Valenz Care.

Plan/PPO Ambulatory Surgical Facility means a Preferred Provider Organization Ambulatory Surgical Facility that has been approved by Blue Cross Blue Shield of Illinois to provide services to the member at the time services are rendered.

Plan/PPO Hospital means a Hospital that has a written agreement with Blue Cross Blue Shield of Illinois to provide services to the member at the time services are rendered.

Call the Fund Office at 1-708-449-7373 or Blue Cross Blue Shield at 1-800-810-BLUE (2583) or visit the Blue Cross Blue Shield of Illinois website at www.bcbsil.com to find out if a particular Hospital is a Plan/PPO Hospital.

Plan/PPO Skilled Nursing Facility means a Skilled Nursing Facility that has a written agreement with Blue Cross Blue Shield of Illinois to provide services to you or your Dependents at the time services are rendered.

Call or write the Fund Office before admission to a Skilled Nursing Facility to verify that the facility is a Plan/PPO Skilled Nursing Facility.

Prescription Drugs may be either Brand Name Drugs or Generic Drugs. Both types of drugs may be listed on the Express Scripts Formulary.

1. A **Brand Name Drug** is a new drug that has come to market for the first time, for which the drug company that manufactures it has a patent to be the sole manufacturer for a particular number of years.
2. A **Generic Drug** is the equivalent of the Brand Name Drug produced by other manufacturers after the patent has expired. A Generic Drug usually serves the same purpose as the original medication, but generally costs less than the Brand Name Drug.
3. A **Formulary Drug List** is the preferred drug list prepared by ESI that lists both Generic and Brand Name Drugs that can be used to treat a condition or symptom. The list is compiled by a team of Pharmacists and Physicians who review the Formulary Drug List and make changes as necessary and as new drugs come to market.

Provider means any healthcare facility such as a Hospital, Skilled Nursing Care Facility, or inpatient rehabilitation facility or any person such as a Physician duly licensed to render covered services to you or your Dependents when Medically Necessary. Providers include the following: Ambulatory Surgical Facility, Dental Hygienist, Dentist, Dialysis Facility, Hospital, or inpatient rehabilitation facility, occupational, speech, or physical therapist, pharmacy, Physician, Registered Nurse or Licensed Practical Nurse or Skilled Nursing Care Facility.

Reasonable and Customary Charge means:

1. For a network provider, the Reasonable and Customary Charge is the negotiated fee/rate set forth in the agreement with the participating health network, provider, facility, or organization and the Plan.

2. For an out-of-network provider, the Reasonable and Customary Charge means the amount that the Plan will pay for a particular service or supply. The Plan will pay no more than 120% of the Medicare allowable amounts for Physician charges and no more than 150% of the Medicare allowable amounts for facility charges for out-of-network claims.

Sickness means illness or disease that causes loss covered by the Fund. Losses incurred because of pregnancy, childbirth and related medical conditions are covered under the Fund to the same extent as any other Sickness.

Skilled Nursing Facility means an institution or a distinct part of an institution that:

1. Has a transfer agreement with one or more Hospitals,
2. Is primarily engaged in providing comprehensive post-acute Hospital and rehabilitative Inpatient care, and
3. Is duly licensed by the appropriate governmental authority to provide such services.

Skilled Nursing Facility does not mean institutions that provide only minimum care, custodial care services, ambulatory or part-time care services or institutions that primarily provide for the care and treatment of Mental or Nervous Disorders, Pulmonary Tuberculosis or Substance Abuse.

Substance Abuse means the uncontrollable or excessive abuse of addictive substances including but not limited to: alcohol, cocaine, morphine, heroin, opium, cannabis and other barbiturates, amphetamines, tranquilizers and/or hallucinogens and the resultant physiological and/or psychological dependency that develops with continued use of such addictive substances requiring medical care as determined by a Physician.

Appendix A:
DURABLE MEDICAL EQUIPMENT AND SUPPLIES

The Trustees have the authority and discretion to determine what constitutes Durable Medical Equipment and covered supplies for items not listed, and when to rent, lease or purchase the equipment.

Covered Supplies

Automatic Blood Pressure Monitor (Blood Pressure Cuff)
Alternating Pressure Point Pads
Apnea Monitor- C-Pap, all Types to Include Oral Devices
Bed Pans
Blood Plasma or Whole Blood
Bone Growth Stimulators
Braces (except dental)
Breast Pumps
Canes and Crutches
Casts, Splints, Binders (such as cervical collars, knee braces or crutches)
Cologuard – Home Screen Testing
Commodes, all types (purchase or rental)
Compression Garment (inflatable & non-inflatable including surgical stockings and Sleeves – Six (6) per Calendar Year)
Custom Foot Orthotics (ordered by Covered Provider) 1 Pair Per Year From Anniversary Date
Diabetic Shoes to include diabetic arch supports and
Orthotics (ordered by Covered Provider) 1 Pair Per
Year From Anniversary Date
Electro-Larnyx
Glucose Monitor and related diabetic supplies covered through Pharmacy Benefit Manager (PBM)
Eyeglasses (First Pair Purchased After Cataract Surgery)
Face Down Chair and Beds for After Eye Surgery (rental)
Hospital Beds (manual or electric)
Infusion Pumps (enteral or parenteral nutritional therapy only)
Intermittent Compression Units
Kidney Hemodialysis Machines
Mobility Equipment: Walkers, Wheelchairs and Accessories, Motor Scooters, Roll-Abouts, Knee Scooters
Muscle Stimulators (used during therapy)
Nebulizers
Nerve Stimulator
Orthotic Devices
Ostomy Supplies (for colostomy or ileostomy)
Oxygen and Rental Equipment (for the administration of oxygen)
Pacemakers
Penile Implants
Post-operative Braces, Shoes and Boots
Prosthesis, Artificial Limbs or Eyes (except replacement thereof)
Radium, Radioactive Isotopes and X-ray Therapy
Roll-A-About (rental or purchase)
Shoes Infants – Oxford shoes used as a brace for congenital diagnosis or medical necessity diagnosis (1 pair per year from anniversary date)
Surgical Bras (post-mastectomy) – Six (6) pairs per calendar year
Surgical Dressing (therapeutic and protective coverings applied to wounds or lesions either on the skin or opening to the skin in connection with a surgical procedure performed by a Surgeon, including: adhesive tape, roll gauze, bandages, and disposable compression material)
Therapeutic Mattress
Traction Equipment
Ultra-Violet Equipment
Ventilators
Wigs/Toupees – Cranial Prosthesis

Non-Covered Supplies

Bathtub or Shower
Seat/Bench/Chair
Beds/Lounge
Biofeedback Equipment
Cervical Pillow
Circulators
Colonic Irrigation Units
Communication Devices
Environmental Equipment including: Air Cleaner, Air Filter, Humidifier, Air Conditioner, Dehumidifier, Precipitator, and Vaporizers
Exercise Equipment
Exercycle
Food Blenders
Formula (Food-Nutritional Supplements, Covered with Medical Diagnoses)
Gravetonical Traction Device
Handrails
Heating Pads
Hot Tubs
Hydraulic Lifts – Hoyer Lifts (rental)
Lifts, Transfer Boards/Bench
Massage Devices
Nocturnal Enuresis Devices
Sauna Baths/Sitz Baths
Heel Lifts
Water Piks
Whirlpools/Whirlpool Equipment