COVER

Important phone numbers are inside front cover

APRIL 1, 2016

IMPORTANT TELEPHONE NUMBERS

Fund Office	**(314) 652-8175** **www.smwbenefits.org**
Coventry/CMR **List of Providers**	**(800)775-3540** **www.CMRnetwork.com**
Utilization Management **medical necessity of services** **for hospital setting and length of confinement**	**contact Coventry/CMR** **(800)546-4603**
LDI Pharmacy Benefit Services	**(314) 652-4121** **1-866-516-3121** **www.ldirx.com**
E4 Health **Member Assistance Program**	**(800) 765-9124**
Delta Dental of Missouri	**(314) 656-3001 or** **1-800-335-8266** **www.deltadentalmo.com**

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April 1, 2016

SUMMARY OF BENEFITS

THIS SUMMARY SCHEDULE IS SUBJECT TO ALL OF THE TERMS AND LIMITATIONS OF THIS PLAN.

MEDICAL BENEFITS FOR ALL MEMBERS AND QUALIFIED DEPENDENTS

1. Coventry/CMR (Tier One) and Wrap (Tier Two) Networks

The Welfare Fund primarily provides benefits through Coventry Health Care of Missouri, an Aetna Company, d/b/a Care Management Resources (Coventry/CMR). Under this arrangement, benefit levels vary with the network status of the provider used. The highest benefits are paid when you use Tier One CMR Preferred Provider Organization (PPO) providers. Benefits are reduced when you use Tier Two or Non-Network providers. Although the highest level of benefits are paid when using Tier One network Providers, Members and Qualified Dependents do not have to select a primary care Physician or obtain referrals to see a specialist. Members are free to use any provider at any time.

In addition to its primary contract with CMR, the Fund has contracts with some more specialized networks such as mental health and transplant networks. If you utilize a provider in one of these ancillary networks you will receive the Tier One in-network benefits. If a provider participates in more than one network to which the Fund has access the Fund will pay the provider based on the network that provides the greatest discount to both the Fund and the Member or Qualified Beneficiary. In some cases, the Fund Office or a case manager can negotiate a further discount with a provider that participates in one of the networks. In that case, the benefit will be based on the negotiated amount.

Outside the geographic area covered by CMR and the specialized networks, the Fund may have one or more contracts with wrap network(s). Benefits for covered services obtained from wrap network providers are paid at the Tier Two/Out-of-Area benefit level. The Plan pays a lower percentage of the allowed amount under the Tier Two/Out-of-Area benefit than it pays for a Tier One claim but a higher percentage than is paid for non-network claims. You can call the Fund Office for information about Tier Two wrap network providers.

A current list of participating CMR providers can be found on the internet at www.cmrnetwork.com. However, in order to ensure the most up-to-date information, Members should contact CMR at the telephone number listed on the medical identification card to verify whether a Physician, Hospital or other health care provider is a participating member of the network.

2. Out-of-Area (Tier Two) Benefits

In addition to providers in the Wrap Network(s), claims will be covered under the Tier Two benefit if they meet the definition of Out-of-Area benefits. The Out-of-Area benefit applies if either (1) the Member or Qualified Dependent lives 50 or more miles from any provider in the CMR or Mental Health (E4 Health) networks providing the type of care sought or (2) the Member or Qualified Dependent needs the care when he is more than 150 miles away from home and more than 50 miles from any CMR or E4 Health provider providing the type of care sought. The Out-of-Area provider needs to be geographically closer than a Tier 1 or 2 network provider providing the same type of care.

3. Co-payments/Co-insurance

The Plan will pay benefits according to the Schedule of Benefits. You are responsible for any Co-payment amount and applicable Deductible amounts in addition to the percentage not payable by the plan (Co-insurance).

Co-payments should be paid directly to the provider at the time of service. Co-payment amounts for most services apply towards the out-of-pocket maximum and the Calendar Year Deductible. The exceptions are set out in the Schedule of Benefits and elsewhere in this Summary Plan Description. The Covered Charges remaining after the satisfaction of the required Co-payment will be paid at the benefit percentage shown.

4. Deductibles/Maximum Lifetime Benefits/Out-Of-Pocket Maximum

A. Calendar Year Deductibles. Medical, Chemical Dependency and Behavioral Health benefits are subject to an annual deductible. The deductible applies to all services except as noted in the Schedule of Benefits and in Sec. 6.2 beginning on page 45.

B. Lifetime and Annual Maximum Benefits. The Plan does not have a Lifetime Maximum Benefit or Annual Maximum Benefit for any Essential Health Benefits. Annual maximums may remain for benefits other than Essential Health Benefits such as Dental, Vision, Accident and Sickness, and AD&D benefits.

C. Out-of-Pocket Maximums.

(1) The Medical Out-of-Pocket Maximum is the maximum amount of Tier One and Tier Two covered medical co-insurance, deductible, and co-pays payable by any Plan participant during a Plan year.

Once the medical maximum amount has been paid by a covered individual or family during a calendar year, the Plan will pay 100% of additional eligible Tier One and Tier Two expenses incurred during that calendar year. Co-payments and co-insurance will continue to apply to benefits that are not Essential Health Benefits.

The following charges are not counted in calculating the Medical Out-of-Pocket Maximum:

(a) vision and dental charges;

(b) expenses above the Usual, Customary and Reasonable payment level;

(c) other non-covered expenses; and

(d) non-network claims.

(2) There is a separate Out-of-Pocket Maximum for Specialty Drugs of $500 per year. Amounts applied to the Specialty Drug Out-of-Pocket Maximum also apply to the general medical annual Out-of-Pocket Maximum.

(3) There is also a separate Prescription Drug Out-of-Pocket Maximum for medication obtained through the LDI prescription drug benefit, see the schedule of benefits.

SCHEDULES OF BENEFITS

The following are summaries of medical benefits payable under the Plan. Please see Articles VI (Comprehensive Medical Benefits – General Information), VII (Comprehensive Medical Benefits – Covered Charges and Exclusions), VIII (Mental Health and Substance Use Disorder Charges), IX (Prescription Drug Coverage), X (Hearing aids and Vision Benefits), and XI (Dental Benefits) for a detailed description of covered charges as well as the Plan exclusions and limitations. Retired Member Benefits are described in Article XII.

In all cases the Schedules of Benefits only apply to expenses and services covered under the Plan.

The following rules related to non-network ancillary services apply to all benefits:

1. When services of non-network radiologists, pathologists, and anesthesiologists are arranged for by an in-network Physician and services are performed during an Inpatient or Outpatient Hospital stay, then the allowed charges (Usual and Customary amount) from such non-network providers are reimbursed at the same level of benefits as the facility where the services were performed.

2. When services are rendered by non-network emergency room Physicians working in an in-network Hospital, such non-network emergency room Physicians' fees (up to the Usual and Customary amount) are reimbursed on the same network basis as the Hospital where services were rendered.

3. When unbeknownst to the patient, a non-network specialist Physician is arranged for by an in-network Physician for services rendered during an Inpatient Hospital stay, then the allowed charges (Usual and Customary amount) for the non-network specialist are reimbursed on the same network basis as the soliciting Physician.

4. When non-network ambulance services are used to transfer a patient to a facility, such ambulance services are reimbursed, based on the Usual and Customary amount, on the same network basis as the facility to which the patient was transferred.

SCHEDULE OF BENEFITS A
ACTIVE MEMBERS

Class I: Active Members
Class II: Administrative Members
Class III: Owner-Members
Class V: Self-Pay Members
Class VI: COBRA Members

A.1 MEDICAL BENEFITS (ACTIVE MEMBERS AND THEIR DEPENDENTS)

Benefits for Office Employee Members (Class IV) and Class VIII (Medicare Retirees) are set out in separate schedules.

Benefit	**Tier One CMR**	**Tier Two FirstHealth/Out -of Area**	**Tier Three Non-Network**
Percentages Paid, generally	80%	70%	50%
Calendar Year Deductible (CYD)	$200 Individual $600 Family	$500 Individual $1,500 Family	$1,000 Individual $3,000Family
Out-of-Pocket Maximums Tier 1 & 2 combined	$4,000 Individual $8,000 Family		Not Applicable
Emergency & Urgent Care			
Emergency Room	Deductible & Co-payment of $115, then 80%		
Urgent Care Center	$55 co-pay then 80%	$85 co-pay then 70%	$115 co-pay then 50%
Ambulance	No Deductible 80%	No Deductible 75%	No Deductible 75%
Inpatient Care			
Inpatient Hospital	Deductible then 80%	Deductible then 70%	Deductible then 50%
Surgery-Physician	Deductible then 80%	Deductible then 70%	Deductible then 50%
Assistant Surgeon If Medically Necessary	Deductible then 80%	Deductible then 70%	not a covered expense
Physician Hospital Care	No Deductible 80%	No Deductible 70%	No Deductible 50%
Preadmission Testing	No Deductible 80%	No Deductible 70%	No Deductible 50%
Second Surgical Opinion	No Deductible & Covered at 100%		Not a Covered Expense
Anesthesia	No Deductible 80%	No Deductible 70%	No Deductible 50%
Skilled Nursing Facility Following Inpatient Stay (60 day maximum)	No Deductible 80%	No Deductible 70%	No Deductible 50%
Outpatient Care			
Outpatient Surgery - Hospital	Deductible & Co-payment of $115, then 80%	Deductible & Co-payment of $170, then 70%	Not a Covered Expense
Outpatient Hospital Other	Deductible then 80%	Deductible then 70%	Deductible then 50%
Outpatient Surgery Center	Deductible & Co-payment of $115, then 80%	Deductible & Co-payment of $170, then 70%	Not a Covered Expense
Physician Care outpatient (other than office visit)	No Deductible 80%	No Deductible 70%	No Deductible 50%
Anesthesia – outpatient care	No Deductible 80%	No Deductible 70%	No Deductible 50%
Colonoscopy - non-routine	Deductible then 80%	Deductible then 70%	Not a Covered Expense
Renal Dialysis	Deductible then 80%	Deductible then 70%	Deductible then 50%
Lasik Eye Surgery	See Vision Care Benefits in this Schedule		
Office Services			
Physician Office Visit	$25 co-pay, then 100%	$35 co-pay, then 100%	Deductible, then 50%

Benefit	Tier One CMR	Tier Two FirstHealth/Out -of Area	Tier Three Non-Network
Specialist Office Visit	$40 co-pay, Then 100%	$50 co-pay, Then 100%	Deductible, Then 50%
Surgery in Office	No Deductible 80%	No Deductible 70%	No Deductible 50%
Physician Assistant	80% of the amount that would have been allowed as a covered expense had the services been rendered by a physician		Not a Covered Expense
Non-routine Diagnostic Testing (X-Ray, Lab Charges) & interpretation	No Deductible 80%	No Deductible 70%	No Deductible 50%
Preventive Care including routine diagnostic testing	No Deductible & Covered at 100%		Not a Covered Expense
Chemotherapy Radiation inpatient or outpatient facility	Deductible then 80%	Deductible then 70%	Deductible then 50%
Chemotherapy Radiation in physician's Office	No Deductible 80%	No Deductible 70%	No Deductible 50%
Chiropractic Care (per visit)	$25 co-payment then 100%	$35 co-payment then 100%	Not a Covered Expense
Smoking cessation treatment for Members and spouses	See Prescription Benefits		
Acupuncture	Not a Covered Expense		
Physical Therapy and Occupational Therapy	No Deductible, then 80%	No Deductible, then 70%	No Deductible, then 50%
Cardiac Rehabilitation Therapy	Deductible, then 80%	Deductible, then 70%	Deductible, then 50%
Speech Therapy see Sec. 7.3(12)	Deductible then 80%	Deductible then 70%	Deductible then 50%
Home Health Care	Deductible then 80%	Deductible then 70%	Deductible then 50%
Hospice Care	No Deductible 80%	No Deductible 70%	No Deductible 50%
Nursing Care RN/LPN	Deductible, then 80%	Deductible, then 70%	Deductible, then 50%
Home Drug Therapy	Deductible then 80%	Deductible then 70%	Deductible then 50%
Durable Medical Equipment see Sec. 7.3(7)	Separate CYD[1] then 80%	Separate CYD[1] then 70%	Separate CYD[1] then 50%
CPAP	The Plan pays 100% without a deductible when the CPAP is purchased through a vendor approved by the Fund Office. There is no benefit for CPAP devices purchased from a provider other than one approved by the Fund Office.		
Diabetic Supplies	No Deductible 80%	No Deductible 70%	No Deductible 50%
Hearing Aids	The Plan pays the first $1,000 per ear for medically necessary hearing aids prescribed by a physician in ear, nose, and throat (ENT)		
Wigs/Hair Pieces	No Deductible, then 80%		

[1] Unless otherwise indicated, amounts applied to the deductible apply to the Calendar Year Deductible (CYD) which only needs to be met once. For the separate CYD for Durable Medical Equipment, another deductible is charged even if the member has met the CYD, unless the Medical Out of Pocket Maximum has been reached in which case there will not be an additional DME deductible.

Benefit	All Tiers
Specialty Drugs	Specialty drugs obtained through LDI Specialty Pharmacy and utilize a co-pay assist program have no member co-pay applied. Specialty drugs obtained through LDI Specialty Pharmacy with no co-pay assist program will have a 25% co-insurance with a maximum $500 out-of-pocket. Specialty drugs obtained from any source other than LDI Specialty Pharmacy are payable at 30% of the LDI allowable rate.

A.2 PRESCRIPTION DRUG COVERAGE (See Article IX)

The Fund has an agreement with LDI that gives Members and Qualified Dependents access to discounted prices for prescription medications at participating LDI pharmacies and by mail order. Prescription drug benefits are not subject to any deductible, however if you purchase a covered medication at a participating LDI retail or mail order pharmacy using your LDI card, you will be required to pay a co-pay, which depends on the type of medication, as follows:

	Generic	Preferred Brand	Non-Preferred Brand
30 Day Co-pay	$15	$50	$80
90 Day Co-pay	$37.50	$125	$200
Calendar Year Out-of-Pocket Maximum (Tier 1 & 2 combined):	$2,850 Individual $5,700 Family		Not Applicable

Each prescription obtained for the first time is limited to a maximum of a 30-day supply. Mail Order and retail LDI Pharmacies allow for a 31 to 90-day supply of maintenance prescriptions for 2½ times the 30-day co-pay. After the second 30-day fill of a maintenance medication you are required to use the mail order, the plan will not pay for additional fills at a retail pharmacy.

If the discounted price of the drug is less than the co-pay listed above, you pay only the discounted price.

Benefits will be payable at non-LDI retail pharmacies if a Member or Qualified Dependent obtains a prescription while traveling or on vacation and can only go to a non-participating pharmacy. There are national pharmacy chains, such as Walgreens and CVS, in the network so you should be able to find a network pharmacy in most places. If a prescription is obtained from a non-LDI pharmacy, the Member or Qualified Dependent must pay the pharmacy for the cost of the prescription and submit a claim to the Fund Office. Such Non-LDI pharmacy claims will be reimbursed in full less the applicable co-payment. This non-participating pharmacy benefit only applies to a 30 day or less supply of medication.

Specialty Drugs are covered under the Medical Coverage benefits of the Plan not the prescription drug benefits.

A.3 MENTAL HEALTH AND SUBSTANCE USE DISORDER CHARGES (See Article VIII)

Mental Health and Substance Use Disorder (MHSUD) benefits are covered the same as any other medical benefit based upon the nature of the provider and the services provided.

The Fund has an arrangement with E4 Health network for use of its network of MHSUD providers. MHSUD claims incurred with E4 Health network providers will be paid at the Tier One deductibles and co-payment rates for medical claims.

In order to receive the maximum benefit for Mental Health and Substance Use Disorder services, you must use an E4 Health network provider.

The Plan also provides a Member Assistance Program (MAP) for all covered Members and their Qualified Dependents through E4 Health. This Program is provided so our Members can receive the best care necessary for their specific problems. Although you are not required to do so, you are encouraged to contact the MAP at (800) 765-9124.

A.4 VISION BENEFITS (See Article X)

The vision program is self-funded through the Sheet Metal Local 36 Welfare Fund using the CMR provider network. Claims should be submitted the same as any other medical claim to CMR at the address on the inside front cover.

Benefit	**Tier One CMR**	**Tier Two FirstHealth/Out-of-Area**	**Tier Three Non-Network**
Vision Exam	$60 Maximum	$60 Maximum	$60 Maximum
Single Vision Lens	$60 Allowance	$60 allowance	$60 allowance
Bifocal Lens	$80 Allowance	$80 allowance	$80 allowance
Trifocals	$100 Allowance	$100 allowance	$100 allowance
Lenticular Lens	$120 Allowance	$120 allowance	$120 allowance
Frames	$100 Allowance	$100 allowance	$100 allowance
Contact Lens	$170 Allowance	$170 Allowance	$170 Allowance
Lasik Surgery	after $200 Deductible paid at 90% to Maximum $1000/eye	after $200 Deductible paid at 90% to Maximum $1000/eye	after $200 Deductible paid at 90% to Maximum $1000/eye

You may select a vision provider of your choice, however, the amount you pay after the allowance will generally be less if you use a CMR provider. All CMR providers and some other providers will accept assignment and allow us to pay them directly; however, non-CMR providers are not required to do so. If your provider will not accept assignment you will need

to pay the bill in full and submit the receipt to the benefit office for reimbursement. Charges above the allowance are the responsibility of the Member or Qualified Dependent and do not apply to the Calendar Year Deductible or the Out-of-Pocket Maximum. The Plan does not cover contact lenses and frames in the same calendar year. See Sec. 10.2 for details.

A.5 DENTAL BENEFITS (See Article XI)

The dental program is self-funded through the Sheet Metal Local 36 Welfare Fund. The Plan uses the Delta Dental of Missouri (DDMO) nationwide system of dental benefit providers. Claims are processed through DDMO.

You may visit the dentist of your choice and select any dentist on a treatment-by-treatment basis, however, your out-of-pocket costs will vary depending on whether you use a Delta Dental PPO dentist, a Delta Dental Premium dentist, or an out-of-network dentist. See Sec. 11.5 for an explanation of how the DDMO network can save you money.

Benefit	**PPO**	**Premier**	**Non-Network**
Preventive	100% No Deductible	100% No Deductible	80% No Deductible
Basic	85%	80%	60%
Major	70%	50%	50%
Orthodontics	50%	50%	Not a Covered Expense
Calendar Year Deductible	$75 Individual; $225 Family	$100 Individual; $300 Family	$150 Individual; $450 Family
Calendar Year Maximum	$2,500	$1,500	$1,000
Lifetime Orthodontic Maximum	$2,000	$2,000	Not a Covered Expense

If a dependent up to age 19 uses a dentist in the plan's dental network then there is no maximum for dental or orthodontic care. Deductibles and co-payments continue to apply.

A.6 ACCIDENT & SICKNESS BENEFIT

(Does not apply to beneficiaries, office employees, COBRA participants, or retirees)

Waiting period: 5 days regardless of reason for benefit

Benefit Amount: $70 per working day

Maximum number of days: 170 days or commencement of Long Term Disability benefits under a Sheet Metal Pension Plan, whichever occurs first.

SCHEDULE OF BENEFITS B
CLASS IV: OFFICE EMPLOYEE MEMBERS

B.1 MEDICAL BENEFITS FOR CLASS IV MEMBERS (Office Employees and their Dependents)

Benefits for Active Members (Classes I, II, III, V, VI and VII) and Class VIII (Medicare Retirees) are set out in separate schedules.

Benefit	**Tier One CMR**	**Tier Two FirstHealth/Out -of Area**	**Tier Three Non-Network**
Percentages Paid, generally	75%	65%	45%
Calendar Year Deductible (CYD)	$500 Individual $1,500 Family	$600 Individual $1,800 Family	$1,050 Individual $3,150Family
Out-of-Pocket Maximums **Tier 1 & 2 combined**	$4,000Individual $8,000 Family		Not Applicable
Emergency & Urgent Care			
Emergency Room	Deductible & Co-payment of $115, then 75%		
Urgent Care Center	$55 co-payment then 75%	$85 co-payment then 65%	$115 co-payment then 45%
Ambulance	No Deductible 75%	No Deductible 70%	No Deductible 70%
Inpatient Care			
Inpatient Hospital	Deductible then 75%	Deductible then 65%	Deductible then 45%
Surgery-Physician	Deductible then 75%	Deductible then 65%	Deductible then 45%
Assistant Surgeon If Medically Necessary	Deductible then 75%	Deductible then 65%	Not a covered expense
Physician Hospital Care	No Deductible 75%	No Deductible 65%	No Deductible 45%
Preadmission Testing	No Deductible 75%	No Deductible 65%	No Deductible 45%
Second Surgical Opinion	No Deductible & Covered at 100%		Not a Covered Expense
Anesthesia	No Deductible 75%	No Deductible 65%	No Deductible 45%
Skilled Nursing Facility Following Inpatient Stay (60 Day Maximum)	No Deductible 75%	No Deductible 65%	No Deductible 45%
Outpatient Care			
Outpatient Surgery – Hospital	Deductible & Co-payment of $115, then 75%	Deductible & Co-payment of $170, then 65%	Not a Covered Expense
Outpatient Hospital Other	Deductible then 75%	Deductible then 65%	Deductible then 45%
Outpatient Surgery Center	Deductible & Co-payment of $115, then 75%	Deductible & Co-payment of $170, then 65%	Not a Covered Expense
Physician Care outpatient (other than office visit)	No Deductible 75%	No Deductible 65%	No Deductible 45%
Anesthesia – outpatient care	No Deductible 75%	No Deductible 65%	No Deductible 45%
Colonoscopy - non-routine	Deductible then 75%	Deductible then 65%	Not a Covered Expense
Renal Dialysis	Deductible then 75%	Deductible then 65%	Deductible then 45%
Lasik Eye Surgery	See Vision Care Benefits in this Schedule		

Benefit	Tier One CMR	Tier Two FirstHealth/Out -of Area	Tier Three Non-Network
Office Services			
Physician Office Visit	$25 co-payment, then 100%	$35 co-payment, then 100%	Deductible, then 45%
Specialist Office Visit	$40 co-pay, Then 100%	$50 co-pay, Then 100%	Deductible, Then 45%
Surgery in Office	No Deductible 75%	No Deductible 65%	No Deductible 45%
Physician Assistant	75% of the amount that would have been allowed as a covered expense had the services been rendered by a physician		Not a Covered Expense
Non-routine Diagnostic Testing (X-Ray, Lab Charges) & interpretation	No Deductible 75%	No Deductible 65%	No Deductible 45%
Preventive Care including routine diagnostic testing	No Deductible & Covered at 100%		Not a Covered Expense
Chemotherapy Radiation inpatient or outpatient facility	Deductible then 75%	Deductible then 65%	Deductible then 45%
Chemotherapy Radiation in physician's Office	No Deductible 75%	No Deductible 65%	No Deductible 45%
Chiropractic Care (per visit)	$25 co-payment then 100%	$35 co-payment then 100%	Not a Covered Expense
Smoking cessation treatment for Members and spouses	See Prescription Benefits		
Acupuncture	Not a Covered Expense		
Physical Therapy and Occupational Therapy	No Deductible, then 75%	No Deductible, then 65%	No Deductible, then 45%
Cardiac Rehabilitation Therapy	Deductible, then 75%	Deductible, then 65%	Deductible, then 45%
Speech Therapy see Sec. 7.3(12)	Deductible then 75%	Deductible then 65%	Deductible then 45%
Home Health Care	Deductible then 75%	Deductible then 65%	Deductible then 45%
Hospice Care	No Deductible 75%	No Deductible 65%	No Deductible 45%
Nursing Care RN/LPN	Deductible, then 75%	Deductible, then 65%	Deductible, then 45%
Home Drug Therapy	Deductible then 75%	Deductible then 65%	Deductible then 45%
Durable Medical Equipment see Sec. 7.3(7)	Separate CYD [2] then 75%	Separate CYD[2] then 65%	Separate CYD[2] then 45%
CPAP	The Plan pays 100% without a deductible when the CPAP is purchased through a vendor approved by the Fund Office. There is no benefit for CPAP devices purchased from a provider other than one approved by the Fund Office.		
Diabetic Supplies	No Deductible 75%	No Deductible 65%	No Deductible 45%
Hearing Aids	The Plan pays the first $1,000 per ear for medically necessary hearing aids prescribed by a physician in ear, nose, and throat (ENT)		
Wigs/Hair Pieces	No Deductible, then 75%		

[2] Unless otherwise indicated, amounts applied to the deductible apply to the Calendar Year Deductible (CYD) which only needs to be met once. For the separate CYD for Durable Medical Equipment, another deductible is charged even if the member has met the CYD, unless the Medical Out of Pocket Maximum has been reached in which case there will not be an additional DME deductible.

Benefit	All Tiers
Specialty Drugs	Specialty drugs obtained through LDI Specialty Pharmacy and utilize a co-pay assist program have no member co-pay applied. Specialty drugs obtained through LDI Specialty Pharmacy with no co-pay assist program will have a 25% co-insurance with a maximum $500 out-of-pocket. Specialty drugs obtained from any source other than LDI Specialty Pharmacy are payable at 30% of the LDI allowable rate.

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	Generic	Preferred Brand	Non-Preferred Brand
30 Day Co-pay	$15	$50	$80
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Calendar Year Out-of-Pocket Maximum, Tier 1 & 2 combined:	$2,850 Individual $5,700 Family		Not Applicable

Each prescription obtained for the first time is limited to a maximum of a 30-day supply. Mail Order and retail LDI Pharmacies allow for a 31 to 90-day supply of maintenance prescriptions for 2½ times the 30-day co-pay. After the second fill of a maintenance medication you are required to use the mail order, the plan will not pay for additional fills at a retail pharmacy.
If the discounted price of the drug is less than the copayment listed above, you pay only the discounted price.

Benefits will be payable at non-LDI retail pharmacies if a Member or Qualified Dependent obtains a prescription while traveling or on vacation and can only go to a non-participating pharmacy. There are national pharmacy chains, such as Walgreens and CVS, in the network so you should be able to find a network pharmacy in most places. If a prescription is obtained from a non-LDI pharmacy, the Member or Qualified Dependent must pay the pharmacy for the cost of the prescription and submit a claim to the Fund Office. Such Non-LDI pharmacy claims will be reimbursed in full less the applicable co-payment. This non-participating pharmacy benefit only applies to a 30 day or less supply of medication.

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B.3 MENTAL HEALTH AND SUBSTANCE USE DISORDER CHARGES (See Article VIII)

Mental Health and Substance Use Disorder (MHSUD) benefits are covered the same as any other medical benefit based upon the nature of the provider and the services provided.

The Fund has an arrangement with E4 Health network for use of its network of MHSUD providers. MHSUD claims incurred with E4 Health network providers will be paid at the Tier One deductibles and co-payment rates for medical claims.

In order to receive the maximum benefit for Mental Health and Substance Use Disorder services, you must use an E4 Health network provider.

The Plan also provides a Member Assistance Program (MAP) for all covered Members and their Qualified Dependents through E4 Health. This Program is provided so our Members can receive the best care necessary for their specific problems. Although you are not required to do so, you are encouraged to contact the MAP at (800) 765-9124.

B.4 VISION BENEFITS (See Article X)

The vision program is self-funded through the Sheet Metal Local 36 Welfare Fund using the CMR provider network. Claims should be submitted the same as any other medical claim to CMR at the address on the inside front cover.

Benefit	**Tier One CMR**	**Tier Two FirstHealth/Out-of-Area**	**Tier Three Non-Network**
Vision Exam	$60 Maximum	$60 Maximum	$60 Maximum
Single Vision Lens	$60 Allowance	$60 allowance	$60 allowance
Bifocal Lens	$80 Allowance	$80 allowance	$80 allowance
Trifocals	$100 Allowance	$100 allowance	$100 allowance
Lenticular Lens	$120 Allowance	$120 allowance	$120 allowance
Frames	$100 Allowance	$100 allowance	$100 allowance
Contact Lens	$170 Allowance	$170 Allowance	$170 Allowance
Lasik Surgery	after $200 Deductible paid at 90% to Maximum $1000/eye	after $200 Deductible paid at 90% to Maximum $1000/eye	after $200 Deductible paid at 90% to Maximum $1000/eye

You may select a vision provider of your choice, however, the amount you pay after the allowance will generally be less if you use a CMR provider. All CMR providers and some other providers will accept assignment and allow us to pay them directly; however, non-CMR providers are not required to do so. If your provider will not accept assignment you will need to pay the bill in full and submit the receipt to the benefit office for reimbursement. Charges above the allowance are the responsibility of the Member or Qualified Dependent and do not apply to the Calendar Year Deductible or the Out-of-Pocket Maximum. The Plan does not cover contact lenses and frames in the same calendar year. See Sec. 10.2 for details.

B.5 DENTAL BENEFITS (See Article XI)

The dental program is self-funded through the Sheet Metal Local 36 Welfare Fund. The Plan uses the Delta Dental of Missouri (DDMO) nationwide system of dental benefit providers. Claims are processed through DDMO.

You may visit the dentist of your choice and select any dentist on a treatment-by-treatment basis, however, your out-of-pocket costs will vary depending on whether you use a Delta Dental PPO dentist, a Delta Dental Premier dentist, or an out-of-network dentist. See Sec. 11.5 for an explanation of how the DDMO network can save you money.

Benefit	**PPO**	**Premier**	**Non-Network**
Preventive	100% No Deductible	100% No Deductible	80% No Deductible
Basic	50%	50%	50%
Major	50%	50%	50%
Orthodontics	50%	50%	Not a Covered Expense
Calendar Year Deductible	$75 Individual; $225 Family	$100 Individual; $300 Family	$150 Individual; $450 Family
Calendar Year Maximum	$1,000	$1,000	$1,000
Lifetime Orthodontic Maximum	$2,000	$2,000	Not a Covered Expense

If a dependent up to age 19 uses a dentist in the plan's dental network then there is no maximum for dental or orthodontic care. Deductibles and co-payments continue to apply.

B.6 ACCIDENT & SICKNESS BENEFIT

This benefit does not apply to office employees, COBRA members and retirees.

SCHEDULE OF BENEFITS C
NON-MEDICARE RETIREES

Non-Medicare Retirees:

- Non-Medicare Retiree Plan A is described as follows in schedule 1C
- Non-Medicare Retiree Plan B described as follows in schedule 2C

NOTE about Medicare Retirees:

- Effective January 1, 2014, the Welfare Plan stopped providing Self-Insured medical coverage to Medicare Retirees.
- Medicare Retirees are eligible to enroll in a Humana Advantage Plan sponsored by the International SMART Union.
- Medicare Retirees are eligible to enroll in vision/hearing aid benefits and/or dental benefits through the Welfare Plan.

1C NON-MEDICARE RETIREES PLAN A

1C.1 MEDICAL BENEFITS

Benefits for Active Members (Classes I, II, III, V, VI and VII) and Office Employee Members (Class IV) are set out in separate schedules. Benefits under Non-Medicare Retiree Plan B are in section 2C.

Benefit	**Tier One CMR**	**Tier Two FirstHealth/Out -of Area**	**Tier Three Non-Network**
Percentages Paid, generally	80%	70%	50%
Calendar Year Deductible (CYD)	$400 Individual $1200 Family	$500 Individual $1,500 Family	$1,000 Individual $3,000Family
Out-of-Pocket Maximums Tier 1 & 2 combined	$4,000 Individual $8,000 Family		Not Applicable
Emergency & Urgent Care			
Emergency Room	Deductible & Co-payment of $115, then 80%		
Urgent Care Center	$55 co-payment then 80%	$85 co-payment then 70%	$115 co-payment then 50%
Ambulance	No Deductible 80%	No Deductible 75%	No Deductible 75%
Inpatient Care			
Inpatient Hospital	Deductible then 80%	Deductible then 70%	Deductible then 50%
Surgery-Physician	Deductible then 80%	Deductible then 70%	Deductible then 50%
Assistant Surgeon If Medically Necessary	Deductible then 80%	Deductible then 70%	not a covered expense
Physician Hospital Care	No Deductible 80%	No Deductible 70%	No Deductible 50%
Preadmission Testing	No Deductible 80%	No Deductible 70%	No Deductible 50%
Second Surgical Opinion	No Deductible & Covered at 100%		Not a Covered Expense
Anesthesia	No Deductible 80%	No Deductible 70%	No Deductible 50%
Skilled Nursing Facility Following Inpatient Stay (60 Day Maximum)	No Deductible 80%	No Deductible 70%	No Deductible 50%
Outpatient Care			
Outpatient Surgery - Hospital	Deductible & Co-payment of $115, then 80%	Deductible & Co-payment of $170, then 70%	Not a Covered Expense
Outpatient Hospital Other	Deductible then 80%	Deductible then 70%	Deductible then 50%
Outpatient Surgery Center	Deductible & Co-payment of $115, then 80%	Deductible & Co-payment of $170, then 70%	Not a Covered Expense
Physician Care outpatient (other than office visit)	No Deductible 80%	No Deductible 70%	No Deductible 50%
Anesthesia – outpatient care	No Deductible 80%	No Deductible 70%	No Deductible 50%
Colonoscopy - non-routine	Deductible then 80%	Deductible then 70%	Not a Covered Expense
Renal Dialysis	Deductible then 80%	Deductible then 70%	Deductible then 50%
Lasik Eye Surgery	See Vision Care Benefits in this Schedule		

Benefit	Tier One CMR	Tier Two FirstHealth/Out -of Area	Tier Three Non-Network
Office Services			
Physician Office Visit	$25 co-payment, then 100%	$35 co-payment, then 100%	Deductible, then 50%
Specialist Office Visit	$40 co-payment, Then 100%	$50 co-payment, Then 100%	Deductible, Then 50%
Surgery in Office	No Deductible 80%	No Deductible 70%	No Deductible 50%
Physician Assistant	80% of the amount that would have been allowed as a covered expense had the services been rendered by a physician		Not a Covered Expense
Non-routine Diagnostic Testing (X-Ray, Lab Charges) & interpretation	No Deductible 80%	No Deductible 70%	No Deductible 50%
Preventive Care including routine diagnostic testing	No Deductible & Covered at 100%		Not a Covered Expense
Chemotherapy Radiation inpatient or outpatient facility	Deductible then 80%	Deductible then 70%	Deductible then 50%
Chemotherapy Radiation in physician's Office	No Deductible 80%	No Deductible 70%	No Deductible 50%
Chiropractic Care (per visit)	$25 co-pay then 100%	$35 co-pay then 100%	Not a Covered Expense
Smoking cessation treatment for Members and spouses	See Prescription Benefits		
Acupuncture	Not a Covered Expense		
Physical Therapy and Occupational Therapy	No Deductible, then 80%	No Deductible, then 70%	No Deductible, then 50%
Cardiac Rehabilitation Therapy	Deductible, then 80%	Deductible, then 70%	Deductible, then 50%
Speech Therapy see Sec. 7.3(12)	Deductible then 80%	Deductible then 70%	Deductible then 50%
Home Health Care	Deductible then 80%	Deductible then 70%	Deductible then 50%
Hospice Care	No Deductible 80%	No Deductible 70%	No Deductible 50%
Nursing Care RN/LPN	Deductible, then 80%	Deductible, then 70%	Deductible, then 50%
Home Drug Therapy	Deductible then 80%	Deductible then 70%	Deductible then 50%
Durable Medical Equipment see Sec. 7.3(7)	Separate CYD [3] then 80%	Separate CYD[3] then 70%	Separate CYD[3] then 50%
CPAP	The Plan pays 100% without a deductible when the CPAP is purchased through a vendor approved by the Fund Office. There is no benefit for CPAP devices purchased from a provider other than one approved by the Fund Office.		
Diabetic Supplies	No Deductible 80%	No Deductible 70%	No Deductible 50%
Hearing Aids	The Plan pays the first $1,000 per ear for medically necessary hearing aids prescribed by a physician in ear, nose, and throat (ENT)		
Wigs/Hair Pieces	No Deductible, then 80%		

[3] Unless otherwise indicated, amounts applied to the deductible apply to the Calendar Year Deductible (CYD) which only needs to be met once. For the separate CYD for Durable Medical Equipment, another deductible is charged even if the member has met the CYD, unless the Medical Out of Pocket Maximum has been reached in which case there will not be an additional DME deductible.

Benefit	All Tiers
Specialty Drugs	Specialty drugs obtained through LDI Specialty Pharmacy and utilize a co-pay assist program have no member co-pay applied. Specialty drugs obtained through LDI Specialty Pharmacy with no co-pay assist program will have a 25% co-insurance with a maximum $500 out-of-pocket. Specialty drugs obtained from any source other than LDI Specialty Pharmacy are payable at 30% of the LDI allowable rate.

1C.2 PRESCRIPTION DRUG COVERAGE (See Article IX)

The Fund has an agreement with LDI that gives Members and Qualified Dependents access to discounted prices for prescription medications at participating LDI pharmacies and by mail order. Prescription drug benefits are not subject to any deductible, however if you purchase a covered medication at a participating LDI retail or mail order pharmacy using your LDI card, you will be required to pay a co-pay, which depends on the type of medication, as follows:

	Generic	Preferred Brand	Non-Preferred Brand
30 Day Co-pay	$15	$50	$80
90 Day Co-pay	$37.50	$125	$200
Calendar Year Out-of-Pocket Maximum Tier 1 & 2 combined:	$2,850Individual $5,700Family		Not Applicable

Each prescription obtained for the first time is limited to a maximum of a 30-day supply. Mail Order and retail LDI Pharmacies allow for a 31 to 90-day supply of maintenance prescriptions for 2½ times the 30-day co-pay. After the second 30-day fill of a maintenance medication you are required to use the mail order, the plan will not pay for additional fills at a retail pharmacy.

If the discounted price of the drug is less than the co-pay listed above, you pay only the discounted price.

Benefits will be payable at non-LDI retail pharmacies if a Member or Qualified Dependent obtains a prescription while traveling or on vacation and can only go to a non-participating pharmacy. There are national pharmacy chains, such as Walgreens and CVS, in the network so you should be able to find a network pharmacy in most places. If a prescription is obtained from a non-LDI pharmacy, the Member or Qualified Dependent must pay the pharmacy for the cost of the prescription and submit a claim to the Fund Office. Such Non-LDI pharmacy claims will be reimbursed in full less the applicable co-payment. This non-participating pharmacy benefit only applies to a 30 day or less supply of medication.

Specialty Drugs are covered under the Medical Coverage benefits of the Plan not the prescription drug benefits.

1C.3 MENTAL HEALTH AND SUBSTANCE USE DISORDER CHARGES (See Article VIII)
Mental Health and Substance Use Disorder (MHSUD) benefits are covered the same as any other medical benefit based upon the nature of the provider and the services provided.

The Fund has an arrangement with E4 Health network for use of its network of MHSUD providers. MHSUD claims incurred with E4 Health network providers will be paid at the Tier One deductibles and copayment rates for medical claims.

In order to receive the maximum benefit for Mental Health and Substance Use Disorder services, you must use an E4 Health network provider.

The Plan also provides a Member Assistance Program (MAP) for all covered Members and their Qualified Dependents through E4 Health. This Program is provided so our Members can receive the best care necessary for their specific problems. Although you are not required to do so, you are encouraged to contact the MAP at (800) 765-9124.

1C.4 VISION BENEFITS (See Article X)

The vision program is self-funded through the Sheet Metal Local 36 Welfare Fund using the CMR provider network. Claims should be submitted the same as any other medical claim to Coventry/CMR at the address on the inside front cover.

Benefit	**Tier One CMR**	**Tier Two FirstHealth/Out-of-Area**	**Tier Three Non-Network**
Vision Exam	$60 Maximum	$60 Maximum	$60 Maximum
Single Vision Lens	$60 Allowance	$60 allowance	$60 allowance
Bifocal Lens	$80 Allowance	$80 allowance	$80 allowance
Trifocals	$100 Allowance	$100 allowance	$100 allowance
Lenticular Lens	$120 Allowance	$120 allowance	$120 allowance
Frames	$100 Allowance	$100 allowance	$100 allowance
Contact Lens	$170 Allowance	$170 Allowance	$170 Allowance
Lasik Surgery	after $200 Deductible paid at 90% to Maximum $1000/eye	after $200 Deductible paid at 90% to Maximum $1000/eye	after $200 Deductible paid at 90% to Maximum $1000/eye

You may select a vision provider of your choice, however, the amount you pay after the allowance will generally be less if you use a CMR provider. All CMR and some other providers will accept assignment and allow us to pay them directly; however, non-CMR providers are not required to do so. If your provider will not accept assignment you will need to pay the bill in full and submit the receipt to the benefit office for reimbursement. Charges above the allowance

are the responsibility of the Member or Qualified Dependent and do not apply to the Calendar Year Deductible or the Out-of-Pocket Maximum. The Plan does not cover contact lenses and frames in the same calendar year. See Sec. 10.2 for details.

1C.5 DENTAL BENEFITS (See Article XI)

The dental program is self-funded through the Sheet Metal Local 36 Welfare Fund. The Plan uses the Delta Dental of Missouri (DDMO) nationwide system of dental benefit providers. Claims are processed through DDMO.

You may visit the dentist of your choice and select any dentist on a treatment-by-treatment basis, however, your out-of-pocket costs will vary depending on whether you use a Delta Dental dentist or an out-of-network dentist. See Sec. 11.5 for an explanation of how the DDMO network can save you money.

Benefit	**PPO**	**Premier**	**Non-Network**
Preventive	100% No Deductible	100% No Deductible	80% No Deductible
Basic	85%	80%	60%
Major	70%	50%	50%
Orthodontics	50%	50%	Not a Covered Expense
Calendar Year Deductible	$75 Individual; $225 Family	$100 Individual; $300 Family	$150 Individual; $450 Family
Calendar Year Maximum	$2,500	$1,500	$1,000
Lifetime Orthodontic Maximum	$2,000	$2,000	Not a Covered Expense

If a dependent up to age 19 uses a dentist in the plan's dental network then there is no maximum for dental of orthodontic care. Deductibles and co-payments continue to apply.

1C.6 ACCIDENT & SICKNESS BENEFIT

Does not apply to beneficiaries, office employees, COBRA participants, or retirees.

2C NON-MEDICARE RETIREE PLAN B

2C.1 MEDICAL BENEFITS

Benefits for Active Members (Classes I, II, III, V, VI and VII) and Office Employee Members (Class IV) are set out in separate schedules. Benefits under Non-Medicare Retiree Plan A are in section 1C.

Benefit	**Tier One CMR**	**Tier Two FirstHealth/Out -of Area**	**Tier Three Non-Network**
Percentages Paid, generally	70%	60%	50%
Calendar Year Deductible (CYD)	$600 Individual $1,800 Family	$900 Individual $2,700 Family	$2,250 Individual $6,750 Family
Out-of-Pocket Maximums Tier 1 & 2 combined	$4,000Individual $8,000 Family		Not Applicable
Emergency & Urgent Care			
Emergency Room	Deductible & Co-payment of $115, then 70%		
Urgent Care Center	$55 co-payment then 70%	$85 co-payment then 60%	$115 co-payment then 50%
Ambulance	No Deductible 30%	No Deductible 60%	No Deductible 60%
Inpatient Care			
Inpatient Hospital	Deductible then 70%	Deductible then 60%	Deductible then 50%
Surgery-Physician	Deductible then 70%	Deductible then 60%	Deductible then 50%
Assistant Surgeon If Medically Necessary	Deductible then 70%	Deductible then 60%	Not a covered expense
Physician Hospital Care	No Deductible 70%	No Deductible 60%	No Deductible 50%
Preadmission Testing	No Deductible 70%	No Deductible 60%	No Deductible 50%
Second Surgical Opinion	No Deductible & Covered at 100%		Not a Covered Expense
Anesthesia	No Deductible 75%	No Deductible 65%	No Deductible 50%
Skilled Nursing Facility Following Inpatient Stay (60 Day maximum)	No Deductible 75%	No Deductible 65%	No Deductible 50%
Outpatient Care			
Outpatient Surgery - Hospital	Deductible & Co-payment of $115, then 70%	Deductible & Co-payment of $170, then 60%	Not a Covered Expense
Outpatient Hospital Other	Deductible then 70%	Deductible then 60%	Deductible then 50%
Outpatient Surgery Center	Deductible & Co-payment of $115, then 70%	Deductible & Co-payment of $170, then 60%	Not a Covered Expense
Physician Care outpatient (other than office visit)	No Deductible 70%	No Deductible 60%	No Deductible 50%
Anesthesia – outpatient care	No Deductible 70%	No Deductible 60%	No Deductible 50%
Colonoscopy - non-routine	Deductible then 70%	Deductible then 60%	Not a Covered Expense
Renal Dialysis	Deductible then 70%	Deductible then 60%	Deductible then 50%
Lasik Eye Surgery	See Vision Care Benefits in this Schedule		
Office Services			

Benefit	Tier One CMR	Tier Two FirstHealth/Out -of Area	Tier Three Non-Network
Physician Office Visit	$35 co-payment, then 100%	$50 co-payment, then 100%	Deductible, then 50%
Specialist Office Visit	$50 co-payment, Then 100%	$65 co-payment, Then 100%	Deductible, Then 50%
Surgery in Office	No Deductible 70%	No Deductible 60%	No Deductible 50%
Physician Assistant	70% of the amount that would have been allowed as a covered expense had the services been rendered by a physician		Not a Covered Expense
Non-routine Diagnostic Testing (X-Ray, Lab Charges) & interpretation	No Deductible 70%	No Deductible 60%	No Deductible 50%
Preventive Care including routine diagnostic testing	No Deductible & Covered at 100%		Not a Covered Expense
Chemotherapy Radiation inpatient or outpatient facility	Deductible then 70%	Deductible then 60%	Deductible then 50%
Chemotherapy Radiation in physician's Office	No Deductible 70%	No Deductible 60%	No Deductible 50%
Chiropractic Care (per visit)	$35 co-pay then 100%	$50 co-pay then 100%	Not a Covered Expense
Smoking cessation treatment for Members and spouses	See Prescription Benefits		
Acupuncture	Not a Covered Expense		
Physical Therapy and Occupational Therapy	No Deductible, then 70%	No Deductible, then 60%	No Deductible, then 50%
Cardiac Rehabilitation Therapy	Deductible, then 70%	Deductible, then 60%	Deductible, then 50%
Speech Therapy see Sec. 7.3(12)	Deductible then 70%	Deductible then 60%	Deductible then 50%
Home Health Care	Deductible then 70%	Deductible then 60%	Deductible then 50%
Hospice Care	No Deductible 70%	No Deductible 60%	No Deductible 50%
Nursing Care RN/LPN	Deductible, then 70%	Deductible, then 60%	Deductible, then 50%
Home Drug Therapy	Deductible then 70%	Deductible then 60%	Deductible then 50%
Durable Medical Equipment see Sec. 7.3(7)	Separate CYD [4] then 70%	Separate CYD[4] then 60%	Separate CYD[4] then 50%
CPAP	The Plan pays 100% without a deductible when the CPAP is purchased through a vendor approved by the Fund Office. There is no benefit for CPAP devices purchased from a provider other than one approved by the Fund Office.		
Diabetic Supplies	No Deductible 70%	No Deductible 60%	No Deductible 50%
Hearing Aids	The Plan pays the first $1,000 per ear for medically necessary hearing aids prescribed by a physician in ear, nose, and throat (ENT)		
Wigs/Hair Pieces	No Deductible, then 70%		

[4] Unless otherwise indicated, amounts applied to the deductible apply to the Calendar Year Deductible (CYD) which only needs to be met once. For the separate CYD for Durable Medical Equipment, another deductible is charged even if the member has met the CYD, unless the Medical Out of Pocket Maximum has been reached in which case there will not be an additional DME deductible.

Benefit	All Tiers
Specialty Drugs	Specialty drugs obtained through LDI Specialty Pharmacy and utilize a co-pay assist program have no member co-pay applied. Specialty drugs obtained through LDI Specialty Pharmacy with no co-pay assist program will have a 25% co-insurance with a maximum $500 out-of-pocket. Specialty drugs obtained from any source other than LDI Specialty Pharmacy are payable at 30% of the LDI allowable rate.

2C.2 PRESCRIPTION COVERAGE (See Article IX)

The Fund has an agreement with LDI that gives Members and Qualified Dependents access to discounted prices for prescription medications at participating LDI pharmacies and by mail order. Prescription drug benefits are not subject to any deductible amounts, however if you purchase a covered medication at a participating LDI retail or mail order pharmacy using your LDI card, you will be required to pay a co-pay, which depends on the type of medication, as follows:

	Generic	Preferred Brand	Non-Preferred Brand
30 Day Co-pay	$15	$50	$80
90 Day Co-pay	$37.50	$125	$200
Calendar Year Out-of-Pocket Maximum, Tier 1 & 2 combined:	$2,850 Individual $5,700 Family		Not Applicable

Each prescription obtained for the first time is limited to a maximum of a 30-day supply. Mail Order and retail LDI Pharmacies allow for a 31 to 90-day supply of maintenance prescriptions for 2½ times the 30-day co-pay. After the second 30-day fill of a maintenance medication you are required to use the mail order, the plan will not pay for additional fills at a retail pharmacy.

If the discounted price of the drug is less than the co-pay listed above, you pay only the discounted price.

Benefits will be payable at non-LDI retail pharmacies if a Member or Qualified Dependent obtains a prescription while traveling or on vacation and can only go to a non-participating pharmacy. There are national pharmacy chains, such as Walgreens and CVS, in the network so you should be able to find a network pharmacy in most places. If a prescription is obtained from a non-LDI pharmacy, the Member or Qualified Dependent must pay the pharmacy for the cost of the prescription and submit a claim to the Fund Office. Such Non-LDI pharmacy claims will be reimbursed in full less the applicable co-payment. This non-participating pharmacy benefit only applies to a 30 day or less supply of medication.

Specialty Drugs are covered under the Medical Coverage benefits of the Plan not the prescription drug benefits.

2C.3 MENTAL HEALTH AND SUBSTANCE USE DISORDER CHARGES (See Article VIII)

Mental Health and Substance Use Disorder (MHSUD) benefits are covered the same as any other medical benefit based upon the nature of the provider and the services provided.

The Fund has an arrangement with E4 Health network for use of its network of MHSUD providers. MHSUD claims incurred with E4 Health network providers will be paid at the Tier One deductibles and co-pay rates for medical claims.
In order to receive the maximum benefit for Mental Health and Substance Use Disorder services, you must use an E4 Health network provider.

The Plan also provides a Member Assistance Program (MAP) for all covered Members and their Qualified Dependents through E4 Health. This Program is provided so our Members can receive the best care necessary for their specific problems. Although you are not required to do so, you are encouraged to contact the MAP at (800) 765-9124.

2C.4 VISION BENEFITS (See Article X)

The vision program is self-funded through the Sheet Metal Local 36 Welfare Fund using the CMR provider network. Claims should be submitted the same as any other medical claim to Coventry/CMR at the address on the inside front cover.

Benefit	**Tier OneCMR**	**Tier Two FirstHealth/Out-of-Area**	**Tier Three Non-Network**
Vision Exam	$60 Maximum	$60 Maximum	$60 Maximum
Single Vision Lens	$60 allowance	$60 allowance	$60 allowance
Bifocal Lens	$80 allowance	$80 allowance	$80 allowance
Trifocals	$100 allowance	$100 allowance	$100 allowance
Lenticular Lens	$120 allowance	$120 allowance	$120 allowance
Frames	$100 allowance	$100 allowance	$100 allowance
Contact Lens	$170 Allowance	$170 Allowance	$170 Allowance
Lasik Surgery	after $200 Deductible paid at 90% to Maximum $1000/eye	after $200 Deductible paid at 90% to Maximum $1000/eye	after $200 Deductible paid at 90% to Maximum $1000/eye

You may select a vision provider of your choice, however, the amount you pay after the allowance will generally be less if you use a CMR provider. All CMR providers and some other providers will accept assignment and allow us to pay them directly; however, non-CMR providers are not required to do so. If your provider will not accept assignment you will need to pay the bill in full and submit the receipt to the benefit office for reimbursement. Charges

above the allowance are the responsibility of the Member or Qualified Dependent and do not apply to the Calendar Year Deductible or the Out-of-Pocket Maximum. The Plan does not cover contact lenses and frames in the same calendar year. See Sec. 10.2 for details.

2C.5 DENTAL BENEFITS (See Article XI)

The dental program is self-funded through the Sheet Metal Local 36 Welfare Fund. The Plan uses the Delta Dental of Missouri (DDMO) nationwide system of dental benefit providers. Claims are processed through DDMO.

You may visit the dentist of your choice and select any dentist on a treatment-by-treatment basis, however, your out-of-pocket costs will vary depending on whether you use a Delta Dental PPO dentist, a Delta Dental Premium dentist, or an out-of-network dentist. See Sec. 11.5 for an explanation of how the DDMO network can save you money.

Benefit	**PPO**	**Premier**	**Non-Network**
Preventive	100% No Deductible	80% No Deductible	Not a Covered Expense
Basic	80%	50%	50%
Major	50%	50%	50%
Orthodontics	Not a Covered Expense	Not a Covered Expense	Not a Covered Expense
Calendar Year Deductible	$75 Individual; $225 Family	$100 Individual; $300 Family	$150 Individual; $450 Family
Calendar Year Maximum	$1,500	$1,000	$1,000

If a dependent up to age 19 uses a dentist in the plan's dental network then there is no maximum for dental or orthodontic care. Deductibles and co-payments continue to apply.

2C.6 ACCIDENT & SICKNESS BENEFIT

This benefit does not apply to office employees, COBRA members and retirees.

ARTICLE I GENERAL INFORMATION

1.1 NAME OF PLAN

International Association of Sheet Metal, Air, Rail and Transportation Workers ("SMART") Local Union No. 36 Welfare Fund. In this booklet it is called the “Plan” or “Welfare Plan.”

1.2 PLAN SPONSOR AND PLAN ADMINISTRATOR

Board of Trustees of SMART Local 36 Welfare Fund
2319 Chouteau Avenue, Suite 300
St. Louis, MO 63103
(314) 652-8175

www.smw36benefits.org

1.3 TYPE OF ADMINISTRATION

The day-to-day affairs of the Fund are handled by employees, hired by the Trustees. These employees work in the office of the Fund, which is located in the SMART Local Union No. 36 building at the address shown above in Sec. 1.2.

(a) The Plan uses the Coventry/CMR (referred to as CMR) networks of Physicians, Hospitals and other medical providers, as well as one or more wrap PPO Network. The Trustees have also engaged providers to perform predetermination services. You or your provider should contact the Fund Office to initiate a predetermination.

CMR and any wrap network do not have the responsibility to actually provide any benefits. All of the benefits are paid directly out of the assets of the Fund.

(b) For Mental Health and Substance Use Disorder (MHSUD) benefits, in addition to providers available through the CMR and wrap networks, the Plan uses the E4 Health Network.

Predetermination services for MHSUD services are provided by E4 Health. You can initiate a predetermination by contacting the Fund Office or by calling E4 Health directly. If you are using a CMR provider or a non-network provider for MHSUD services you should still contact E4 Health for a predetermination, you cannot rely on a predetermination from CMR in connection with MHSUD services.

E4 Health
105 Decker Ct., Suite 475
Irvine, TX 75062
(800)765-9124

(c) Claims for prescription drug benefits are reviewed by LDI under contract with the Fund through your pharmacy benefit card. The Fund also purchases access to the LDI's pharmacy network. Claims for prescription drug benefits are paid from Fund assets.

(d) Claims for vision benefits are paid directly from Fund assets. Claims and questions should be directed to the Fund Office.

(e) Claims for dental benefits are paid from Fund assets, however, claims and questions should be directed to Delta Dental of Missouri.

1.4 PLAN IDENTIFICATION NUMBERS

The Plan's EIN is: 43-0681778. The Plan Number is 501.

1.5 TYPE OF PLAN

Employee Welfare Plan established to provide self-administered and self-funded Hospital and medical expense reimbursement, accidental death and dismemberment benefits, temporary accident and sickness income benefits, prescription drug, vision and dental benefits.

1.6 BOARD OF TRUSTEES

Dave C. Zimmermann, Chair
SMART Local Union No. 36
2319 Chouteau Avenue
St. Louis, MO 63103

George L. Welsch, Co-chair
Welsch Heating and Cooling Co.
P.O. Box 28545
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Michael C. Corrigan
Lyons Sheet Metal Co.
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SMART Local Union No. 36
2319 Chouteau Avenue
St. Louis, MO 63103

William Meeh
RF Meeh Co.
325 Sun Valley Circle
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SMART Local Union No. 36
2319 Chouteau Avenue
St. Louis, MO 63103

1.7 SERVICE OF LEGAL PROCESS

The agent for service of legal process is Plan Administrator, 2319 Chouteau Avenue, Suite 300 , St. Louis, Missouri 63103. Service may also be made upon any Plan Trustee.

1.8 COLLECTIVE BARGAINING AGREEMENT

The Plan is maintained pursuant to one or more Collective Bargaining Agreements between SMART Local Union No. 36 and various sheet metal contractors. Under the Collective Bargaining Agreements the Employers agree to the terms of the Plan Trust Agreement and they agree to make contributions to this Fund.

1.9 CONTRIBUTING EMPLOYERS

A participant or beneficiary upon written request to the Plan Administrator will be told whether a particular employer is a contributing Employer to this Plan.

1.10 SOURCE OF CONTRIBUTIONS AND METHOD OF CALCULATION

All Employers party to a Collective Bargaining Agreement providing for support of this Plan are required to make contributions for hours worked by Employees under such Agreement. Contributions for apprentices are lower, proportionate to apprentice wage rates. SMART Local Union No. 36 makes contributions for certain of its own Employees, and the Trust Funds, to which SMART Local Union No. 36 is party, make contributions for their Employees. Eligible participants about to lose coverage and retirees may self-pay for certain coverage's under the terms of the Plan. The Trustees may allow other groups to participate. There are special rules for working employers, which includes a participant whose spouse is the owner of the business, see Article III.

1.11 FUNDING AND BENEFIT PAYMENTS

All contributions paid to the Trust Fund and any income from Trust Fund assets are the property of the Trust Fund. The Trust Fund itself is the only source for payment of most benefits. These benefits are payable only to the extent that there are assets available in the Trust Fund. The Trustees have made estimates of reserves needed to pay benefits; these reserves are invested.

The Trustees may pay fees to various insurers and other vendors for access to medical, dental and vision networks, PBM services, MAP services, and AD&D and life insurance. Except for the insured benefits (for example AD&D and life), no claims are paid by any of those organizations on behalf of the Plan.

1.12 PLAN YEAR

The Plan's fiscal records are maintained on a calendar year, ending December 31.

1.13 LIMITATIONS ON AUTHORITY

No agent, representative, officer, employee or other person from the Union, any Employer or the Employer Association, nor any individual Trustee or employee of the Trust Fund, has any authority to speak on behalf of this Trust Fund. If you have any questions pertaining to this Plan, the employees in the Plan Administrator's office will try to assist you by referring you to the pertinent provisions in this booklet or in other plan documents. The office (also called "Fund office") is at the SMART Local Union No. 36 Building, 2319 Chouteau Avenue, Suite 300, St. Louis, Missouri 63103, and the telephone number is (314) 652-8175. None of these employees, or anyone else, has the authority to act contrary to the Plan Documents. Matters that are not clear and which require interpretation will be referred to the Board of Trustees.

The Board of Trustees has the sole authority and discretion to interpret, construe, and apply all of the terms of this Summary Plan Description, the Trust Agreement and any other documents governing the operation of this Plan, including any ambiguous terms in such documents. The Trustees will, pursuant to the terms of the Plan Documents, make all final determinations regarding eligibility for benefits and the amount of benefits due participants and beneficiaries. The Trustees have the authority to view Personal Health Information as necessary to make such benefit and eligibility determinations. The decisions of the Trustees will be binding. Any decisions made by the Trustees are intended to be subject to the most deferential standard of judicial review. Benefits under this Plan will be paid only if the Trustees or their designee, the Plan Administrator, decides in their discretion that the individual is entitled to those benefits.

1.14 EFFECTIVE DATE OF REVISED PLAN

Benefits are payable as described in this Summary Plan Description effective on the 1st day of April, 2016, except as modified or amended by the Trustees after the publication of this Summary Plan Description.

1.15 THIS PLAN MAY BE CHANGED

The Trustees retain the authority to change the eligibility rules and to change the benefit program at any time, including the right to terminate the Plan. Such changes may include, but are not limited to: increasing or decreasing any of the benefits, the time or other requirements relating to eligibility, or the classes of persons who may become or remain eligible.

No rights to eligibility or benefits, including retiree benefits are vested. Rights may be changed or terminated.

1.16 HOW BENEFITS MAY BE LOST

(a) Lost or Delayed Eligibility. If a Member or Dependent losses eligibility or does not take the appropriate steps to establish eligibility, benefits may be lost (see Sec. 3.1, Sec. 3.2, Sec. 3.4 and Sec. 3.6 on pages 24 – 28).

(b) Late Benefit Application. If a Member or his Qualified Dependent fails to make a timely application for a benefit, benefits may be lost (See Sec. 16.2 on page 98).

(c) Plan changes. Benefits or eligibility may be reduced or terminated if the Plan is changed (See Sec. 1.15 and Sec. 15.2 on page 96).

1.17 PLAN'S RIGHT OF RECOVERY

If any situation when this Fund may have made payments for which it was not obligated including, but not limited to, Coordination of Benefit and Subrogation, the Employee and his Qualified Dependent shall reimburse this Fund. The Fund has the right to withhold future benefits until there is full reimbursement of amounts that were paid in error.

1.18 PLAN ABUSE

In order to preserve the assets of the Fund for all participants and beneficiaries, it is necessary for the Trustees to protect the Fund from abuse. For purposes of this Plan, abuse shall mean the use of the Plan, by a Member, Dependent, beneficiary, provider, or other person or entity in a way in which is not necessary, or Usual, Customary and Reasonable. Plan abuse includes, but is not limited to, the following:

(a) Submitting claims on behalf of an individual who is not a Member or Qualified Dependent under the terms of the Plan, this includes failing to inform the Fund Office when a spouse or child is no longer a Qualified Dependent, for example after a divorce or when a child reaches age 26, and failing to inform the Fund if a dependent has other coverage which is primary to this Plan.

(b) Seeking treatment from a Hospital emergency room for a medical problem which is not an Emergency and which could have been treated at a clinic or Physician's office.

(c) Undergoing tests for medical problems, which have previously been conducted when there is no medical basis for repeating the tests.

(d) Submitting claims which are clearly not covered under the terms of the Plan.

(e) Obtaining medical treatment for any reason other than the correction of a medical problem or covered wellness benefits.

(f) Submitting claims to the Plan which are the responsibility of a third party, such as an Employer for a Worker's Compensation claim or another insurer or individual in an accident situation, or acting in a way that limits or impedes your recovery from a third party.

Each instance of Plan abuse will be considered by the Trustees on a case by case basis. Any claim which is deemed by the Trustees to constitute Plan abuse is specifically excluded from coverage under the Plan. Further, the Trustees may, upon a finding of Plan abuse, take action against the Member or Dependent including by disqualifying the person or persons involved from further coverage under the Plan and/or withholding future benefits until the fraudulent benefits are repaid to the Fund.

1.19 USE OF ASSETS IF TRUST FUND TERMINATES

Under the terms of the Trust Agreement, after payment or allowance for payment of all necessary expenses of winding up the affairs of the Trust Fund, any remaining assets will be used to continue benefits or to provide a similar type of benefit, to the extent of the assets remaining, for one or more classes of Employees covered by the Plan.

1.20 STATEMENT OF ERISA RIGHTS

As a participant in sheet Metal Local 36 Welfare Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

(a) Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and Collective Bargaining Agreements (CBAs), 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 Pension and Welfare Benefit Administration. The documents will also be made available for inspection at any place of employment, where 50 or more Members are employed, within 10 days of a written request that should be made in writing to the Fund Office, through the Employer.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and CBAs, and

copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

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

(b) Continue Group Health Plan Coverage

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

(c) 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.

(d) Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a 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.

(e) Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, EBSA, 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 EBSA publications hotline at 866-444-3272 or on-line at www.DOL.gov/EBSA/publications/main.html.

1.21 GENDER

The use of the masculine pronoun generally also includes the feminine and vice versa.

1.22 NOTICE OF THE PLAN'S USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION (PHI)

The International Association of Sheet Metal Air, Rail and Transportation Workers ("SMART") Local Union No. 36 Welfare Fund (the Fund) has a duty under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended by Health Information Technology for Economic and Clinical Health Act (HITECH), Title XIII of Division A of the American Recovery and Reinvestment Act (ARRA), to outline the Fund's legal obligations regarding your private medical information. In general, the Fund is required by this law to maintain the privacy of your health information. The Fund must also provide you with a Notice of its legal duties and current privacy practices.

The Fund has the legal obligation to abide by the terms of this Notice, but retains the right to change the terms of this notice. Any changes may be effective for any current health information about you and any information that may be obtained in the future. Such changes will be appropriately reflected in this Notice of Privacy Practices. The most recent version of this Notice will always be available to you through the Fund office.

A. Your Rights: When it comes to your health information, you have certain rights. This section explains your rights and some of the Fund's responsibilities to help you.

(1) Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information the Fund has about you. Ask the Fund office how to do this.
- The Fund will provide a copy or a summary of your health and claims records, usually within 30 days of your request. The Fund may charge a reasonable, cost-based fee.

(2) Ask the Fund to correct health and claims records
- You can ask the Fund to correct your health and claims records if you think they are incorrect or incomplete. Ask the Fund office how to do this.
- The Fund may say "no" to your request, but if so will tell you why in writing within 60 days.

(3) Request confidential communications
- You can ask the Fund to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- The Fund will consider all reasonable requests, and must say "yes" if you say you would be in danger if your request is not granted.

(4) Ask the Fund to limit what is used or shared
- You can ask the Fund not to use or share certain health information for treatment, payment, or Fund operations.
- The Fund is not required to agree to your request, and may say "no" if it would affect your care.

(5) Get a list of those with whom the Fund shared information
- You can ask for a list (accounting) of the times the Fund shared your health information for six years prior to the date you ask, who the Fund shared it with, and why.
- The Fund will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked the Fund to make). The Fund will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

(6) Get a copy of this privacy notice:
- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. The Fund will provide you with a paper copy promptly.

(7) Choose someone to act for you:
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

- The Fund will make sure the person has this authority and can act for you before taking any action.

(8) File a complaint if you feel your rights are violated:

- You can complain if you feel the Fund has violated your rights by contacting:

SMART Local Union No. 36 Welfare Plan
Attn: Privacy Officer
2319 Chouteau Avenue, Suite 300
St. Louis, MO 63103,
Telephone: (314) 652-8175 or 1-800-741-9411
Facsimile: (314) 652-8494

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting: www.hhs.gov/ocr/privacy/hipaa/complaints/.
- The Fund will not retaliate against you for filing a complaint.

B. Your Choices: For certain health information, you can tell the Fund your choices about what is shared. If you have a clear preference for how the Fund shares your information in the situations described below, talk to the Fund office and indicate what you want done, and the Fund will follow your instructions.

(1) In these cases, you have both the right and choice to tell the Fund to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to indicate your preference, for example if you are unconscious, the Fund *may go ahead and share your information if* the Fund office *believes it is in your best interest. The Fund may also share your information when needed to lessen a serious and imminent threat to health or safety.*

(2) In these cases the Fund *never* share your information unless you give written permission:

- Marketing purposes
- Sale of your information

C. The Fund Uses and Disclosures: The Fund typically uses or shares your health information in the following ways.

(1) Help manage the health care treatment you receive

- The Fund can use your health information and share it with professionals who are treating you.

Example: A doctor sends information about your diagnosis and treatment plan so additional services can be arranged.

(2) Run The Fund
- The Fund can use and disclose your information to the Plan and contact you when necessary.
- The Fund is not allowed to use genetic information to decide whether to give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: The Fund *uses health information about you to develop better services for you.*

(3) Pay for your health services
- The Fund can use and disclose your health information when paying claims for your health services.

Example: The Fund shares information about you with your dental plan to coordinate payment for your dental work.

(4) Administer your plan
- The Fund may disclose your health information for plan administration.

Example: The Fund shares information with an insurance company to obtain life insurance and AD&D policies.

D. How Else Can the Fund Use or Share Your Health Information? The Fund is allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. The Fund has to meet many conditions in the law before sharing your information for these purposes.
For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

(1) Help with public health and safety issues. The Fund can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

(2) Do research. The Fund can use or share your information for health research.

(3) Comply with the law. The Fund will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that the Fund is complying with federal privacy law.

(4) Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- The Fund can share health information about you with organ procurement organizations.
- The Fund can share health information with a coroner, medical examiner, or funeral director when an individual dies.

(5) Address workers' compensation, law enforcement, and other government requests. The Fund can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

(6) Respond to lawsuits and legal actions. The Fund can share health information about you in response to a court or administrative order, or in response to a subpoena.

E. The Fund's Responsibilities

(1) The Fund is required by law to maintain the privacy and security of your protected health information.

(2) The Fund will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

(3) The Fund must follow the duties and privacy practices described in this notice and give you a copy of it.

(4) The Fund will not use or share your information other than as described here unless authorized by you in writing. If you tell the Fund it can use or share information, you may change your mind at any time. Let the Fund know in writing if you change your mind.

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

F. Changes to the Terms of this Notice. The Fund can change the terms of this notice, and the changes will apply to all information the Fund has about you. The new notice will be available upon request, on the Fund's web site, and the Fund will mail a copy to you.

ARTICLE II DEFINITIONS

Additional definitions specific to a particular benefit are located elsewhere in this SPD.

2.1 EMPLOYEE

Means a person working under the terms of the SMART Local Union No. 36 Collective Bargaining Agreement, or other Agreement, requiring contributions to this Trust Fund. It also includes employees of SMART Local Union No. 36 and of any Trust Fund to which SMART Local Union No. 36 is a party to the extent that contributions are required and made for such employee.

2.2 MEMBER

Means an Employee who has met the initial eligibility requirements for any benefit and whose eligibility has not been terminated. Effective for contributions due on work performed on or after August 15, 2006, Employees will receive credit for hours worked for which contributions are not received during three months. If your Employer fails to pay contributions for three months and you continue working for that Employer you will not receive credit for any additional hours for which contributions are not received.

2.3 CLASSES OF MEMBERS

Eligible to participate in the Plan are as follows:

CLASS I: Active Member. An Employee of a contractor who is signatory to a SMART Local Union No. 36 Collective Bargaining Agreement (signatory contractor) and who is making contributions to the Plan on behalf of its Employees.

CLASS II: Administrative Member. An Employee of SMART Local Union No. 36 or of a contributing Trust Fund to which Local 36 is a party and for whom contributions to the Plan are required and being made on behalf of the Employee.

CLASS III: Owner-Member. A Member of SMART Local Union No. 36 who owns or materially participates in the Management of a signatory contractor or whose spouse is an owner of or otherwise materially participates in the Management of a signatory contractor. A Member of SMART Local Union No. 36 who, personally or through a spouse, owns or materially participates in the management of a business in the Sheet Metal Industry that is not contributing to this Fund or to another Sheet Metal welfare fund returning contributions to this Fund through reciprocity is an owner of that non-contributing employer for purposes of determining eligibility

for benefits. See Sec. 3.1.B and Sec. 3.2.B on pages 24 and 25, respectively.

CLASS IV: Office Employee Member. An administrative Employee of a signatory contractor for whom the contractor is paying a monthly Welfare premium.

CLASS V: Self-pay Member. A Member of SMART Local Union No. 36 who would lose welfare coverage due to lack of hours worked and is eligible to and elects to continue coverage by paying monthly premiums to the Welfare Fund.

CLASS VI: COBRA Member. An Individual who elects to continue coverage under the Plan for a monthly premium. These individuals include Members whose eligibility terminated and who were not eligible for or did not elect self-pay coverage, children who no longer meet the definition of dependent, a divorced or legally separated spouse of a Member, and the spouse or dependent children of a deceased Member.

CLASS VII: An Eligible retiree or qualified dependent of a retiree who continues coverage through the SMART Local 36 Welfare Fund past the date of retirement but who is not yet eligible for Medicare. Also called a non-Medicare Retiree.

Medicare Retirees: An Eligible retiree, or qualified dependent of a retiree, who is eligible for Medicare may be eligible to enroll in the Medicare Advantage Plan sponsored by the International Union. The Welfare Plan no longer offers medical or prescription drug coverage for this group but individuals may enroll in the Plan's dental benefit, the vision and hearing aid benefit, or both.

2.4 CERTIFICATE OF CREDITABLE COVERAGE

Means a form showing the length of time a person had creditable coverage the Plan, including the starting date, and the coverage effective and termination dates.

The plan will furnish such a certificate in response to the written request of (or on behalf of) a covered person while covered under the plan or within the two years following the termination of coverage.

2.5 CLOSE RELATIVE

Means the spouse, mother, father, sister, brother, child, or in-laws of the Member or Qualified Dependent. The terms mother, father, sister, brother and child include step-parents, step-siblings and step-children.

2.6 CUSTODIAL CARE

Means care which is primarily for the purpose of assisting the individual in the activities of daily living or in meeting personal rather than medical needs and is not therapeutic treatment of an illness or injury. Examples of custodial care are: assistance in dressing, preparation of meals and eating, and toileting, repositioning in bed, prophylactic and palliative skin care, and bathing. In determining whether an individual is receiving custodial care, the factors considered are the level of care, and the medical supervision required and furnished. The decision is not based on diagnosis, type of condition, degree of functional limitation or rehabilitation potential.

2.7 DEPENDENT (QUALIFIED DEPENDENT)

(a) Means the child or spouse of a Member.

(1) A spouse includes anyone who is recognized as a spouse under the law.

If a Member entered into a civil union under the laws of a state recognizing such unions and enrolled a partner in this Plan based upon that civil union prior to July 1, 2015, then the civil union partner will continue to be an eligible dependent as follows: The civil union partner will continue to be considered a Dependent as long as the civil union remains in force and the Member lists the civil union partner as the beneficiary for all death benefits in a manner that, to the extent allowed by law, would provide benefits similar to those provided for a spouse pursuant to ERISA. For example, the Member must list the civil union partner as a pension beneficiary for at least 50% of the pension benefit in place of ERISA's joint and survivor annuity. It will be the responsibility of the Member to inform the Fund if the civil union is dissolved or a civil union partner is not a dependent for purposes of federal or state taxation. A Civil Union partner who was not enrolled in the Plan prior to July 1, 2015 is not considered a spouse.

(i) A Member's legal spouse will be considered a Dependent from the date of marriage (or civil union), or the date of Member's eligibility, whichever is later.

(ii) A spouse will no longer be considered a Dependent in the event of a legal separation, or divorce from the Member, or, in the case of a civil union, the separation of the couple or other termination of the relationship. In the event coverage ends for the spouse, COBRA will be provided to the extent required by law.

(2) Dependent children include the following:

- Natural and step children of the Member.

- Adopted children or children placed in the Member's home for adoption. A child is considered "adopted" only when he is legally adopted or placed for adoption and only if the adoption or placement occurred before the child reached his eighteenth (18^{th}) birthday. A child is placed for adoption when a Member assumes and retains a legal obligation for total or partial support of the child in anticipation of adoption. The child's placement with a Member terminates upon the termination of such legal obligation.

- Foster children residing full-time in the Member's home but only if there is a court or agency order showing such status.

(i) A child will be considered a Dependent from the moment of birth or placement for adoption, the date such child meets the eligibility requirements, or the date of Member's eligibility; whichever is later, as long as the Fund receives timely notice.

(ii) A Member's Dependent child is covered up to the end of the month of his or her 26^{th} birthday.

(3) Adult handicapped children, over the age of 26, will continue to be covered after they would normally lose coverage because of age if they are continuously dependent on the Member because of a physical or mental disability and are incapable of self-sustaining employment at the time they reach the maximum age for coverage as a Dependent. In this situation, the Member must provide proof of the child's dependency and incapacity within 31 days of the date coverage would otherwise end. Disabled children can be covered by the medical, prescription, and dental plans as long as they remain incapacitated and Dependent upon the Member for support, provided proof is submitted when requested. If, any time after the age when Dependent status would otherwise end, the child no longer meets the requirements of this paragraph, then coverage ends.

(4) Any other child as required by the terms of a Qualified Medical Child Support Order.

In the case of a child who does not meet the definition in paragraph 2.7.A(2) and whose coverage was continuing based on full-time student status if the child's student status changes because of a severe illness or injury, then the child will not cease to be a Qualified Dependent before the earlier of: (1) one year after the first day of the medically necessary leave of absence; or (2) the date on which the child's status as a Qualified Dependent would otherwise terminate under the terms of the Plan. To continue coverage under this provision, the Plan must be provided with certification from the child's attending physician.

(b) Class I, II, III and V members automatically have family coverage and, therefore, cannot elect whether or not to cover dependent children. Class IV Office Employees and Class VI and VII members who self-pay may elect individual or family coverage. A member with family coverage may not selectively disenroll a dependent child who otherwise qualifies for coverage under the plan.

(c) The Plan may require documentation in support of a claim that a child is a Dependent of a Member including:

(1) In the case of a natural child, a birth certificate.

(2) In the case of an adopted child, verification of adoption or intent to adopt from the court or placement agency.

(3) In the case of a step-child, copies of a birth certificate for the child, the divorce decree or death certificate for the spouse's prior marriage(s), any child support order that applies to the other natural parent, a copy of the marriage certificate for the Member and spouse, and any additional information that may be required.

(d) Any Dependent must be reported in writing to the Fund Office before a claim arises except in the case of a newborn child. Upon receipt of a claim for a newborn child, the Fund Office will send cards to the Member for completion before the claim is paid. If a Member fails to notify the Trust Fund Office in writing about a newborn or newly adopted Dependent within 30 days of that person becoming a Dependent, benefits will only be paid for claims arising prior to such notice at the discretion of the Trustees, upon a showing of good cause for the delay for a period not to exceed six (6) months. In the case of all other dependents, if a Member notifies the Trust Fund more than 30 days after the person becoming a Dependent then coverage will begin on the first day of the month following notification.

(e) Coordination of Benefit Rules for Dependent Children

The Coordination of Benefit Rules of this Plan provide that coverage under this Plan is secondary to the child's "Employment Based Health Coverage," which is defined as coverage available through the child's employment or the employment of the child's spouse.

The Coordination of Benefit Rules of this Plan also provide that coverage under this Plan is secondary to coverage under the Plan of any parent, step-parent, or other legally responsible person with whom the child resides and to the Plan of any parent or other person responsible for providing coverage under a Qualified Medical Child Support Order.

2.8 DURABLE MEDICAL EQUIPMENT

Means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) is generally not useful to a person in the absence of illness or injury, and (d) is appropriate for use in the home. Equipment which does not fully meet this definition is not covered. For example, the Plan does not cover such things as exercise equipment and saunas.

2.9 EMERGENCY

Means an Illness or Injury which arises suddenly and unexpectedly and manifests itself by acute symptoms of sufficient severity that the absence of immediate medical attention would result in (a) serious jeopardy to the patient's health, or (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part. Examples of conditions that would qualify as emergencies are severe bleeding, heart attack, loss of consciousness, and acute appendicitis. Examples of conditions that would not qualify are elective surgery (surgery that is scheduled in advance), influenza, and a cold.

2.10 EXPERIMENTAL OR INVESTIGATIVE

Means those drugs, devices, medical or dental treatments or procedures which meet the following criteria:

(a) in the case of a drug or device, if it cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and if such approval has not been given at the time the drug or device is provided to the patient;

(b) if the drug, device, medical or dental treatment or procedure, or the patient informed consent document used with any of them, was reviewed and approved by the treating facility's institutional review board or any other body serving a similar function, or if federal law requires such review or approval;

(c) if the drug (or combination of drugs), device, medical or dental treatment or procedure is the subject of an ongoing Phase I or Phase II clinical trial; is the research, experimental, study or investigational arm of an ongoing Phase III clinical trial; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or how any of these factors compares with standard means of treatment or diagnosis;

(d) in the case of a drug or device, if it is prescribed or used "off label," i.e., dispensed for a use for which it is not approved by the U.S. Food and Drug Administration or by the National Comprehensive Cancer Network or by similar guidelines; or

(e) if the drug, device, medical or dental treatment or procedure is considered by the U.S. Department of Health and Human Services Health Care Financing Administration to be investigational, not reasonable and necessary, not primarily medical in nature or not verified as effective by scientific controlled studies.

The Plan covers "routine patient costs" incurred by a "qualified individual" in connection with participation in an "approved clinical trial." See Sec. 7.1(3) on page 50 for coverage in connection with a clinical trial. In addition, the Trustees may, from time to time, consult with a medical consultant, who may, in the exercise of judgment, waive the exclusion of a drug, device, medical treatment or procedure described in subparagraph B, C or D above, provided, however, that they may not waive the exclusion of a drug, device, medical treatment or procedure that is the subject of an ongoing Phase I clinical trial.

2.11 HOSPITAL

Means an institution that:

(a) is legally constituted and licensed as a hospital;
(b) primarily provides medical treatment to registered in-patients who reside overnight on the premises;
(c) have and regularly uses full diagnostic, surgical and therapeutic facilities under the supervision of a full-time staff of one or more Physicians;
(d) regularly provides 24-hour nursing service by Registered Nurses; and
(e) maintains a daily medical record for each inpatient, and must not, except incidentally, be a place of rest, a place for custodial care for the patient.

Unless they meet this definition, institutions such as clinics, skilled nursing facilities, nursing homes, places for rest or treatment of the patient, and other institutions do not qualify as hospitals.

2.12 MAINTENANCE CARE

Means care which is provided to prevent recurrences or worsening of an existing condition and to maintain the patient’s current medical status. An example of maintenance care is chiropractic spinal subluxation or modality to maintain the individual’s current medical status.

2.13 MEDICALLY NECESSARY (MEDICAL NECESSITY)

Means Health care services, supplies or treatment which (a) are in the judgment of the attending Physician or dentist, appropriate and consistent with the diagnosis; (b) in accordance with generally accepted standards of medical practice, and could not have been omitted without adversely affecting the patient's condition or the quality of

medical care rendered; (c) are offered in compliance with standards of safety and efficacy; and (d) are performed in the most cost-efficient manner and type of setting that can be safely provided to the patient and must not be performed principally for the convenience of the provider or patient.

2.14 OUT-OF-AREA

Means outside the Coventry/CMR Service Area. Claims will be covered under the Tier Two Out-of-Area benefits if either (a) the Member or Dependent lives 50 or more miles from a Coventry/CMR provider providing the type of care sought or (b) the Member or Dependent needs the care when he is more than 150 miles away from home and more than 50 miles from a Coventry/CMR provider providing the type of care sought. The Out-of-Area Provider needs to be closer than a Tier 1 or 2 network provider providing the same type of care. For the Out-of-Area benefit the allowable amount is restricted to the Usual and Customary amount and the Member can be billed any amount above Usual and Customary. In all other cases, claims from non-network providers are covered under the out of network benefit.

2.15 PHYSICIAN (DOCTOR)

Means a licensed doctor of medicine, optometry, or osteopathy; a chiropractor, nurse practitioner, licensed mental health professional, or other medical professional who is practicing within the scope of his or her license.

2.16 PHYSICIAN ASSISTANT

Means a person who (a) has graduated from a Physician Assistant Program accredited by the appropriate committee of the American Medical Association (or was employed as a Physician Assistant for at least three years prior to August 28, 1989), (b) is certified as a Physician Assistant by the National Commission on Certification of Physician Assistants and licensed by the applicable governmental agency; and (c) identifies him or herself as a Physician Assistant and is providing health care services delegated by a licensed physician.

2.17 PLAN or PLAN DOCUMENTS

Means the Benefit Program, as set forth in this Summary Plan Description (SPD) as well as the Trust Agreement establishing the Welfare Fund and any Amendments to the SPD or Trust; any Regulations of the Plan; and any insurance policies for insured benefits. The SPD is the Plan Document. It is the primary source of information about the benefits and contains a description of Plan coverage and benefits, limitations and exclusions in language that is intended to be easily understood by Plan participants.

2.18 QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

Means an order, typically issued in a divorce or state child support proceeding, which may create or recognize the right of a child to be covered under this Plan or another plan. Such an order must be qualified and issued by a court of competent jurisdiction or through an administrative process having the force and effect of law for this Plan to be bound by it. On request, the Trustees will provide guidelines used to determine whether a Medical Child Support order is qualified.

2.19 SKILLED NURSING FACILITY

Means only an institution, other than a Hospital which meets all of the following requirements:

(a) maintains permanent and full time facilities for bed care of 10 or more resident patients;
(b) has available at all times the services of a Physician;
(c) has a Registered Nurse (R.N.) or Physician on full time duty in charge of patient care and one or more Registered Nurses (R.N.) or Licensed Practical Nurses (L.P.N.) on duty at all times;
(d) maintains a daily medical record for each patient;
(e) is primarily engaged in providing continuous skilled nursing care for sick or injured persons during the convalescent stage of their Illnesses or injuries and is not, other than incidentally, a rest home or a home for Custodial Care or for the aged;
(f) is operating lawfully as a nursing home in the jurisdiction where it is located; and
(g) maintains staff and facilities with the equipment, training, and skill to treat the individual for whom benefits are sought (for example a facility without a burn unit would not be appropriate for a patient recovering from burns).

2.20 SMART LOCAL UNION NO. 36 AGREEMENT OR COLLECTIVE BARGAINING AGREEMENT

Means a Collective Bargaining Agreement between an Employer and SMART Local Union No. 36 requiring contributions to this Trust Fund.

2.21 SPECIALTY MEDICATION

Specialty Medications are used in treating serious Illnesses and conditions such as cancer, hemophilia, hepatitis C, multiple sclerosis, and rheumatoid arthritis. They are defined oral, injectable, infused, or inhaled medications that are either self-administered or administered by a healthcare provider. Specialty Medications can be used or obtained in the hospital or in either an outpatient or home setting.

There is a specialty drug list maintained by the welfare fund's pharmacy benefit manager. Specialty drugs generally have the following key characteristics:

- Need frequent dosage adjustments
- Cause more severe side effects than traditional drugs
- Need special storage, handling, and/or administration
- Have a narrow therapeutic range
- Require periodic laboratory or diagnostic testing

2.22 TRUST AGREEMENT

Means the International Association of Sheet Metal, Air, Rail and Transportation Workers ("SMART") Local Union No. 36 Welfare Fund Amended Trust Agreement of June 1, 1975, and as thereafter amended. It is the Trust Agreement under which the Trust Fund is maintained.

2.23 USUAL, CUSTOMARY & REASONABLE (UCR) CHARGES

Means the amount charged for the same or similar medical care, services or supplies taking into account the fees and prices generally charged for cases of comparable nature and severity at the time and place such medical care, services or supplies are rendered or received. In general, UCR is calculated based on a percentage of Medicare's allowable amount for the service.

ARTICLE III ELIGIBILITY FOR BENEFITS

3.1 INITIAL ELIGIBILITY FOR BENEFITS
(see Sec. 2.3 beginning on page 14 for definition of each class)

(a) Class I (Active) and Class II (Administrative) Members gain initial eligibility once 400 hours have been worked for a contributing Employer (and contributions paid on these hours) within a period of four or fewer consecutive months. Coverage begins the first day of the second month beginning after the four hundred hours are worked.

Example: A new Member works 100 hours each in March, April, May and June. He becomes eligible for benefits as of August 1, the first day of the second month following the first four-month period (March – June) in which he accumulated 400 hours. He remains eligible at least through August 31 of that year.

(b) Class III (Owner) Members gain initial eligibility under Class I rules, however, Class III Members must report and pay at least 150 hours per month.

(c) Class IV (Office Employee) Members gain initial eligibility when employed on a regular basis for 20 or more hours a week by a contributing Employer and (1) the contributing Employer adds the Employee to its monthly report or (2) a contributing Employer submits a new application for office-employee coverage and is accepted by the Board of Trustees. Monthly premiums are paid to the Welfare Fund by the first of the month for Class IV (Office Employee) Members. The monthly premium is subject to annual adjustments.

(d) Class V (Self-Pay) and Class VI (COBRA) are Members who gained initial eligibility, lost continuing eligibility, and meet the requirements for self-payment. Self-pay is only available to certain classes of Members.

(e) Class VII (non-Medicare Retiree) and Medicare Retiree initial eligibility is established prior to retirement under Class I or II as described above.

3.2 CONTINUED ELIGIBILITY

(a) Continued Eligibility – Class I and Class II

Any Class I (Active) or Class II (Administrative Member) will continue to be eligible as long as he continues to work under a SMART Local Union No. 36 Agreement (or, for a Class II Member continues to work for Local 36 or a Trust Fund) for at least 150 hours in a three month period as explained in the following schedule:

150 hours worked in these three months:	Coverage for the month of:
Aug-Sept-Oct	January
Sept-Oct-Nov	February
Oct-Nov-Dec	March
Nov-Dec-Jan	April
Dec-Jan-Feb	May
Jan-Feb-Mar	June
Feb-Mar-Apr	July
Mar-Apr-May	August
Apr-May-June	September
May-June-July	October
June-July-Aug	November
July-Aug-Sept	December

(b) Continuing Eligibility Class III

An Owner-Member will continue to be eligible as long as the employer continues to report and pay at least 150 hours per month for the Owner-Member and the employer is current in paying its contributions on its Class I employees.

(c) Continuing Eligibility Classes IV, V, VI, VII, and VIII

(1) A Class IV (Office Employee) Member will continue to be eligible for coverage as long as the Member remains eligible through regular employment of twenty or more hours a week with a contributing Employer and the monthly premium is received from the Employer.

(2) A Class V (Self-Pay) and Class VI (COBRA) Member will continue to be eligible for coverage during months for which timely payments are received, and for a Class V (Self-Pay) Member, that the Member remains eligible to self-pay.

(3) A Class VII Member will continue to be eligible for coverage during months for which the Member receives a pension from which payment is made or timely pays the premium. A Medicare Retiree will continue to be eligible for the ancillary benefits as long as any premiums are timely paid.

3.3 RECIPROCITY FOR CLASS I AND CLASS II MEMBERS

The Fund is party to the International Association of Sheet Metal, Air, Rail and Transportation Workers ("SMART") Master Reciprocity Agreement and Addendum C (Health Fund) (Reciprocity Agreement). For purposes of initial eligibility, continued eligibility and termination of eligibility for Class I and II Members, hours also include an

hour worked under a collective bargaining agreement with a local union of the Sheet Metal, Air, Rail and Transportation Workers International Association which is covered by the terms of the Reciprocity Agreement and which is reported and paid to the Welfare Fund.

3.4 TERMINATION OF ELIGIBILITY

(a) Class I (Active) and Class II (Administrative) Members lose eligibility if:

(1) The Member does not work the required number of hours in a three month period to continue coverage as set out in Sec. 3.2;

(2) The Member's Employer fails to make contributions to the Plan for more than three months and as a result the Member is deemed to not work the required number of hours;

(3) The Member's Employer ceases to be a party to a SMART Local Union No. 36 Collective Bargaining Agreement and the Member continues employment with that employer;

(4) The Member's Employer enters into a Collective Bargaining Agreement which does not require the Employer's participation in this Fund and the Member continues employment with that employer;

(5) The Member becomes employed by an Employer who is not legally obligated to contribute to this Fund (a Non-Participating Employer); or

(6) The Member terminates employment with a contributing Employer unless the Member is (1) registered on the hiring hall out of work list as available for work and has not turned down more than three referrals from the hiring hall or (2) working for an employer contributing to another sheet metal welfare fund which is returning contributions to this Fund through reciprocity. A Member cannot remain on the out of work list and, therefore, his eligibility will terminate if he is working in the Sheet Metal industry for an employer who is not contributing to this Fund or to a fund which is returning contributions to this Fund through reciprocity. A member who owns or materially participates in the Management of, or whose spouse is an owner of or materially participates in the Management of, a business in the Sheet Metal Industry that is not contributing to this Fund or to a fund which is returning contributions to this Fund through reciprocity is "working in the Sheet Metal Industry with an employer who is not contributing to this Fund."

A Member who loses eligibility under paragraphs (1) or (2) of this section or who is maintaining eligibility under the SMART Local 36 Equality Fund or SASMI (Stabilization Agreement for Sheet Metal Industry) is eligible to self-pay under Sec. 3.10 beginning on page 29.

(b) Class III, IV, V, VI , VII, and VIII Members lose eligibility if:

(1) Class III (owner member) Members lose eligibility if 150 hours are not reported and paid for the month or if the Employer is delinquent in reporting and paying contributions for its Class I Members;

(2) Class IV (office employee) Members lose eligibility if the Employer fails to timely pay the monthly premium or the Member stops regular employment of twenty or more hours a week for the contributing Employer;

(3) Class V and VI (self-pay and COBRA) Members lose eligibility if the monthly premium is not received by the Fund when due; and

(4) Class VII (retiree) and Medicare Retiree Members (dental, vision and hearing aid benefits) lose eligibility if they notify the Fund Office they wish to terminate coverage, or they cease to receive pension benefits or fail to self-pay any amounts due to the Fund. A Class VII Member becomes a Medicare Retiree Member when he or she becomes eligible for Medicare Part B at which time eligibility for medical and prescription drug benefits with the Plan ends.

(c) Generally Members and dependents lose (or fail to get) eligibility if:

(1) Members in all classes lose eligibility if they become eligible as an employee for benefits under a similar plan of benefits;

(2) Dependents will lose coverage when they no longer meet the definition of Dependent, for example a spouse will lose coverage in the event of a divorce and a child will lose coverage when he no longer meets the age requirement. Except as explicitly allowed, dependents lose coverage if the member is no longer eligible for benefits;

(3) Any Member or dependent, whether active, COBRA or retiree, who is required to self-pay losses eligibility if there is a failure to timely Self Pay;

(4) An unemployed Employee may be eligible for coverage under the SMART Local 36 Equality Fund or SASMI (Stabilization Agreement for Sheet Metal Industry). If benefits are through SASMI, the Employee must promptly secure and file a SASMI health and welfare benefit application form. Failure to do so could result in a loss of eligibility; or

(5) If a Member fails to notify the Trust Fund Office in writing of the presence of a Qualified Dependent within 30 days of that person becoming a Qualified Dependent, benefits will not be paid for claims arising prior to the first day of the month following such notice except, at the discretion of the Trustees, upon a showing of good cause for the delay (See Sec. 2.7 (d) beginning on page 18).

3.5 REINSTATEMENT OF ELIGIBILTY

A former Class I or Class II Member whose eligibility for benefits has terminated for any reason within the prior twelve months, will again become eligible for benefits and be deemed a Member on the first day of the second month following the month that he has worked at least 150 hours under a SMART Local Union No. 36 agreement within a period of three consecutive months. If a former Class I or Class II Member has not been eligible under the Plan for more than twelve months, he can reinstate eligibility only by again meeting the initial eligibility requirements as set out in Sec. 3.1 on page 24.

3.6 RESCISSION OF ELIGIBILITY

A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that the cancellation will be effective back to the time 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 you have been provided with 30 days advance written notice of the rescission of coverage. However, the following situations will not be considered rescissions of coverage and do not require the Plan to give you 30 days advance written notice:

(a) When the Plan terminates your coverage retroactive to the date you lose eligibility, if there is a delay in administrative recordkeeping between your loss of eligibility for coverage and the date the Plan is notified of your loss of eligibility;
(b) When the Plan retroactively terminates your coverage because you fail to make timely self-payments; and
(c) When any unintentional mistakes or errors result in your being covered by the Plan when you should not have been. The Plan will cancel your coverage prospectively once the mistake is identified.

3.7 SPECIAL ELIGIBILITY CREDITS WHEN DISABLED: CLASSES I AND II

Disabled Class I and II Members: A totally disabled Class I or II Member who promptly notifies the Trustees of such condition, will be eligible for continued benefits during the period of disability, up to a maximum of 170 work days per period of disability. Any such period of disability shall count at the rate of 7.5 hours per workday towards the continuing 150-hour requirement. No more than 170 days per period of disability may be allowed unless the Member has returned to active work and would meet the requirements for a period of new disability under Sec. 5.4 on page 42. These credits are applied for both occupational and non-occupational disabilities.

3.8 EXTENSION THROUGH SASMI FOR CLASS I

An unemployed Class I Member may be eligible to have contributions made on his behalf by the SASMI (Stabilization Agreement for the Sheet Metal Industry) Fund under the rules of the SASMI Fund. It is the Member's responsibility to secure and file with this Trust Fund a "Health and Welfare Benefit Application" form, before the date that the Member's benefits would otherwise terminate from this Fund. If the Member has any doubt about his right to have SASMI pay for his continued coverage, the Member should self-pay to retain coverage under the provisions of Sec. 3.10 below.

3.9 SURVIVING SPOUSE OF CLASS I, II, III AND V MEMBERS

The surviving spouse of a Member and other Qualified Dependents of the Member will be eligible for benefits without charge for four (4) months following the month during which the Member dies, after which the surviving spouse and Dependents may be eligible for continuing coverage under COBRA.

3.10 MEMBER SELF-PAYMENT TO RETAIN ELIGIBILITY

(see Sec. 3.14 on page 33 for additional self-pay rights under COBRA).

(a) CLASS I ACTIVE MEMBER SELF-PAYMENT. A Class I Member, about to become ineligible, may provide for his continued eligibility for medical benefits and accidental death and dismemberment benefits as a Class V member by making timely contributions on his own account at the current premium rate (the rate is available by calling the Fund Office). To be eligible for self-payment a Class V Member must be actively seeking employment in the sheet metal industry as demonstrated by remaining registered on the hiring hall out of work list established under the agreement between SMART Local Union No. 36 and the St. Louis Chapter, SMACNA, and by not turning down more than three referrals from the hiring hall.

(1) A Class I Member who has terminated employment is not eligible to make self-payment under this section if he has accepted work in the Sheet Metal Industry with an employer who is not contributing to this Fund or to another Sheet Metal welfare fund returning contributions to this Fund through. (See Sec. 3.4(a) beginning on page 26). In addition, a Class I Member who has terminated eligibility under Plan Sec. 3.4(a)(2) because the Member's Employer failed to make contributions for three months, is not eligible to make self-payment under this section if he continues to work for the Employer that failed to make contributions. A member who owns or materially participates in the Management of, or whose spouse is an owner of or materially participates in the Management of, a business in the Sheet Metal Industry that is not contributing to this Fund or to a fund which is returning contributions to this Fund through

reciprocity is "working in the Sheet Metal Industry with an employer who is not contributing to this Fund."

(2) Self-payment eligibility is limited to a maximum of 12 months between periods of eligibility based on Employer contributions. For example, a Member becomes ineligible due to insufficient contribution hours and begins to self-pay (or to use his SASMI benefit), six months later he returns to work for 3 months during which he has continued his self-payments. If the Member only worked 140 hours during those 3 months before returning to the out-of-work list then the Member is only entitled to 3 more months of self-payment because he has not had a restoration of eligibility based on Employer contributions.

Eligibility to self-pay under this provision ends sooner than 12 months if the Member

(i) fails to make the required self-payment when required by the Fund;

(ii) becomes covered under another employer-sponsored welfare plan or other group health coverage;

(iii) is not available for work because he continues to work for an employer that has ceased to be a SMART Local Union No. 36 Employer or has withdrawn his membership from SMART Local Union No. 36 and is not eligible for the out-of-work list.

(iv) terminates employment with a contributing Employer and is not available for work.

(3) Payment to this Fund by SASMI for extended coverage and continued benefits for disabled Members will be considered as self-payment by the Member under the 12-month limit (See Sec. 3.8 on page 29 and paragraph (2) above). Example: A Member's eligibility terminated January 31 because of insufficient contribution hours. He applies for extended coverage through SASMI and SASMI pays this Trust Fund for 4 months of continue eligibility through May 31. The Member may self-pay for up to an additional 8 months, through January 31 of the next year, at the rate provided under the Plan. Remember Health and Welfare benefits paid by SASMI are subtracted from your underemployment benefit. The 12-month limit may be extended by the Trustees when the Member qualifies for additional months of payments through the Equality Fund during underemployment periods.

(5) After self-payment eligibility ends, a Member may self-pay for an additional 18 months at the COBRA rate (this is not COBRA; it is continuation coverage at the

COBRA rate). Accidental death and dismemberment benefits are not included as part of this continuation coverage.

(b) A Class II Member, about to become ineligible, may provide for his continued eligibility for medical benefits by self-paying the COBRA premium as described in Sec. 3.14 beginning on page 33.

(c) INSTRUCTORS—SELF-PAYMENT. Any Member who becomes an instructor in a school in a subject related to the Sheet Metal Industry is eligible as a Class II Member.

(d) RETIRED MEMBERS AND PRE-RETIREMENT SURVIVING SPOUSES—SELF-PAYMENT – see Article XII, beginning on page 80)

(e) SELF-PAYMENT TIME AND AMOUNTS. The Fund Office bills Members on the first of the following month for coverage if insufficient hours have been reported to the Welfare Fund. A Member will then be notified by the Fund Office when payment is due.

(1) Occasionally, a Class I or II Member works sufficient hours but his Employer has either failed to file reports for those hours or failed to pay the reported contributions to the Welfare Fund. A Class I or II Member will receive credit for hours worked for which contributions are not received during a three month period. If an Employer fails to pay contributions for more than three months the Member will not receive credit for any additional hours for which contributions are not received.

(2) If timely self-payment is not made, coverage will be terminated. Once self-payment coverage is terminated, it may not be reinstated (unless a Member first reinstates his eligibility by returning to work for the required number of hours as set forth in Sec. 3.5 on page 28).

(3) Contact the Fund Office for information about current self-payment rates. Any of the self-payment rates may be changed by the Trustees.

(f) SELF-PAYMENT CANNOT BE STARTED AT A LATE DATE. If a Member or Qualified Dependent has a right to self-pay, that person must start and continue to make self-payments when due.

(1) A Member eligible to self-pay under this section must start payments within the time set forth in the notice from the Fund Office. Continuation payments received after the due date set out in the notice, will be late and will be rejected. If payment is not received on time for any month, the Member or Qualified Dependent loses the right to self-pay thereafter.

(2) A Member eligible for self-pay as a retiree, under this section must make direct payments to the Fund Office for those months prior to the month when his payments from Local 36 Pension Fund begin for early, normal or disability retirement.

Once pension benefits begin, a retiree's self-payment is normally withheld from the Pension benefit check.

(3) Failure to start or to continue payments within the required time results in loss of the self-payment privilege.

3.11 ELIGIBILITY OF DEPENDENTS OF MEMBERS

Qualified Dependents shall be eligible for medical benefits under Articles VI (Comprehensive Medical Benefits – General Information), VII (Comprehensive Medical Benefits –Covered Charges and Exclusions), VIII (Mental Health and Substance Use Disorder (charges), IX (Prescription Drug Coverage), X (Hearing Aids and Vision Benefits), Article XI (Dental Benefits), and Article XII (Retired Member Benefits).

Qualified Dependents of Members become eligible for benefits at the time a Member becomes eligible (or, if later, the date the Qualified Dependent satisfies the Plan's eligibility requirements) and their eligibility shall terminate at the earlier of:

(a) The date the Member's eligibility terminates; or
(b) The date the dependent no longer meets the definition of a Qualified Dependent (see Sec. 2.7 beginning on page 16);
(c) At the end of the fourth month following the death of a Class I, II, III or IV Member, (see Sec. 3.9 on page 29).

Dependents are not eligible for the Accident and Sickness Benefit (Article V).

3.12 ADDITIONAL LIMITATION ON ELIGIBILITY

Aside from other provisions in this Plan which may terminate or limit a Member's eligibility or that of his Dependents, eligibility shall terminate on the earliest of the following dates:

(a) Benefits will end on the date of termination of this Plan.
(b) If Employer contributions necessary to establish or continue eligibility are not actually received by the Trust Fund – that is, if an Employer fails to make required contributions – then, a Class I or II Member will receive credit for hours worked for which contributions are nor received during a three month period. If an Employer fails to pay contributions for more than three month and the Member continues to

work for that Employer then the Member will not receive credit for any additional hours worked for which contributions are not received.

(c) The date a Member or Dependent enters the armed services of any country on active duty. However, if a Member is performing full-time active duty with the United States military, coverage for that Member and any Qualified Dependents will be continued for a period of 31 days, provided that the Member continues to pay any required contribution amounts for Dependent coverage due during that period. If the period of military service exceeds 31 days, and coverage would otherwise terminate because of reduced work hours, Members may, under USERRA, continue their health coverage and that of any covered Dependents from the first day of active military service by paying the Fund's applicable USERRA rate, a rate which will not exceed the COBRA Continuation Coverage rates. Coverage is available for 24 months or the end of the Member's reemployment period, whichever is less. The rules for enrolling in USERRA coverage and paying the premiums are the same as for COBRA.

A Member who was working for an Employer at the time he enters the U.S. Armed Forces and who timely exercised re-employment rights under federal law shall return to the eligibility status that he had on the date he entered the U.S. Armed Forces.

3.13 NO EXTENDED COVERAGE FOR BENEFITS (except under COBRA, as set out in Sec. 3.14)

When the eligibility of a Member or Qualified Dependent terminates, all rights to benefits terminate as of that date. There is no extended coverage for payment of benefits after the date of termination.

3.14 SELF-PAYMENT CONTINUATION RIGHTS UNDER FEDERAL LAW—"COBRA"

Federal law requires the following VERY IMPORTANT NOTICE:

On April 7, 1986, a Federal law (Called "COBRA") was enacted (Public Law 99- 272, Title X) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances ("Qualifying Events") where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. (Both you and your spouse should take time to read this notice carefully.)

In deciding whether to elect COBRA coverage, it is important for you to review your health care options carefully. For example, your decision regarding election of COBRA coverage may impact your rights under the Health Insurance Portability and

Accountability Act related to enrollment in other employer coverage or the purchase of individual insurance and may impact your right to enroll in coverage through the Health Insurance Marketplace or to be eligible for a subsidy in the Marketplace.

When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. For example, you may be eligible to buy an individual plan through the Affordable Care Act's Health Insurance Marketplace. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

However, if there is other coverage available to you or you wish to purchase individual coverage and you elect COBRA coverage that other plan may require that you continue the COBRA coverage for the entire period or until an open enrollment period.

In order to be eligible to continue your coverage under COBRA, you or your Qualified Dependent must be considered a "Qualified Beneficiary" and your coverage must terminate as a result of one of the "Qualifying Events" described below.

A "Qualified Beneficiary" is an Employee or Qualified Dependent who was covered under this Plan on the day immediately preceding the Qualifying Event date and is therefore eligible to continue coverage under the provisions of COBRA. Each Qualified Beneficiary has an independent right to continue his or her coverage. If an Employee has a child born, placed for adoption, or adopted during a period of continuation under this provision, the new child will also be considered a Qualified Beneficiary. Should the Employee's coverage terminate before the end of the applicable maximum coverage period described below, the new child, like other qualified dependents, will have an independent right to continue coverage for the balance of the maximum period. Individuals whose coverage is reduced or eliminated in anticipation of a qualifying event will also be considered Qualified Beneficiaries. Such individuals become eligible to elect COBRA Continuation Coverage upon the occurrence of the qualifying event.

If you are employed by an Employer who is paying contributions for you to this International Association of Sheet Metal, Air, Rail and Transportation Workers ("SMART") Local Union No. 36 Welfare Fund, and if you have met the eligibility requirements for coverage by this Fund: You have a right to choose this continuation coverage for yourself and/or your Qualified Dependents if you lose your group health coverage from the Fund because of a reduction in your hours of employment or termination of your employment (for reasons other than gross misconduct on your part). If your Employer stops making contributions to the Fund, you will not be offered the opportunity to elect COBRA continuation coverage.

If you are the spouse of an eligible Employee covered by this Fund, you have the right to choose continuation coverage if your coverage under this Fund would terminate for any of the following four reasons:

(a) The death of your spouse;
(b) A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
(c) Divorce or legal separation from your spouse; or
(d) Your spouse becomes eligible for Medicare.

If you are Qualified Dependent child of an Employee covered by this Fund, you have the right to continuation coverage if your coverage under this Fund would terminate for any of the following five reasons:

(a) The death of the Employee parent;
(b) The termination of the Employee parent's employment (for reasons other than gross misconduct) or reduction in your Employee parent's hours of employment;
(c) Parents' divorce or legal separation;
(d) The Employee parent becomes eligible for Medicare; or
(e) You cease to be a Qualified Dependent under this Fund.

Under the law, the Employee or family member has the responsibility to inform this Fund of a divorce, legal separation, or a child losing Qualified Dependent status under this Fund within 60 days of the event, which would cause the loss of coverage. If you fail to notify Fund Office within that 60-day period, COBRA Continuation Coverage will NOT be offered.

The Employer making contributions on behalf of an Employee has a responsibility to notify this Fund of the Employee's death, termination of employment or reduction in hours, or Medicare eligibility, however in order to insure that you receive the appropriate notices and election forms, it is a good idea for you or your affected Qualified Dependents to also notify the Fund Office.

When this Fund is notified that one of these Qualifying Events has happened, the Fund will in turn notify you that you have the right to choose continuation coverage. Under the law, you will be given a 60-day election period, during which you must decide whether or not you wish to continue coverage. This 60-day period will begin on the later of: (a) the date the notice of the right to elect continuation coverage is provided, or (b) the date coverage would otherwise terminate as a result of a qualifying event. If you wish to continue your coverage, you must notify the Fund Office in writing before the end of the election period.

If you do not choose continuation coverage, your group health coverage from this Fund will end.

If you choose continuation coverage, the Trustees of this Fund are required to give you health (medical, prescription drug, vision and dental) coverage, which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated Employees or family members. COBRA participants have the same rights as active Employees, including the right to add newly acquired Qualified Dependents due to marriage, birth, adoption, or placement for adoption. If the COBRA participant was not paying for family coverage before this event, the premium will be changed to the family cost if a Qualified Dependent is added. Except for a newly acquired child of the Employee, newly Qualified Dependents cannot extend coverage by a second qualifying event or after the COBRA participant's coverage ends.

COBRA Continuation Coverage must become effective as of the day following termination of your active coverage under the Plan and must be continuous.

Example: If your coverage terminates July 31 because of a reduction in work hours, you must elect continuation coverage effective August 1. You cannot skip August and start coverage September 1. Nor can you skip any later months after you start to pay for continuation coverage without losing your right to continue coverage.

Continuation Coverage may be continued for a maximum of:

(a) 18 months from the date of your termination of employment or reduction in hours, if coverage was lost due to that Qualifying Event.
(b) If a Qualified Beneficiary is determined by the Social Security Administration to be totally disabled as of, or during, the 60 days following the date of the Qualifying Event and so notifies the Fund Office within 60 days after the Social Security Administration's determination and prior to the end of the 18 months, the maximum Continuation Coverage period for the disabled Qualified Beneficiary as well as for every other Qualified Beneficiary who lost coverage due to the same Qualifying Event will be extended for an additional 11 months – for a total of 29 months – but not beyond the end of the first month which ends more than 30 days after the Qualified Beneficiary ceases to be considered totally disabled by the Social Security Administration. The disabled Qualified Beneficiary must notify the Fund Office within 30 days following a determination by the Social Security Administration that he is no longer totally disabled.
(c) If, during the first 18 or 29 months of Continuation Coverage, a Qualified Beneficiary experiences another Qualifying Event, coverage may be extended, but in no case may the total amount of Continuation Coverage be more than 36 months.
(d) 36 months from the date of the original Qualifying Event if a spouse's or child's coverage was lost because of divorce or legal separation, the death of the Member, the Member becoming entitled to Medicare or a child ceasing to be an Qualified Dependent in accordance with Sec. 2.7 beginning on page 16.

The 36-month period cannot be extended more than 36 months beyond the date that the Dependent began self-paying for Continuation Coverage. Example: Because of reduced work hours, a Member elected Continuation Coverage for himself and his dependent wife and child effective January 1, 2015. The maximum duration of this coverage is 18 months through June 2016. His child reaches the maximum age for eligibility as a Dependent in December 2017 and that child elects COBRA for himself; the child can Self-Pay for 36 months from January 2015 through December 2017.

Continuation Coverage may terminate earlier than 18 or 36 months for any of the following reasons:

(a) The premium for your continuation coverage is not paid in a timely manner;
(b) You first become covered under another group health plan after electing continuation coverage.
(c) You first become eligible for Medicare after electing continuation coverage;
(d) If your continuation coverage is extended due to disability and you are finally determined by Social Security Administration to be no longer disabled, continuation coverage will terminate on the first day of the first month that begins more than 30 days after the date of such final determination.
(e) The date the Plan ceases to provide benefits to any participants.

If an Employer stops making contributions to the Fund, and establishes a new group health plan (or starts participating in another multi-employer plan) for a substantial number of its employees who were formerly covered under the Fund, then the plan established by the employer (or the other multi-employer plan) has the obligation to make continuation coverage available to any Qualified Beneficiary who was receiving coverage from the Fund on the day before the cessation of contributions by the employer and who is, or whose Qualifying Event occurred in connection with, a covered Employee whose last employment prior to the qualifying event was with that employer.

If you elect Continuation Coverage, the required premiums must be paid directly to the Fund by you (or by a third party on your behalf). The Trustees will determine annually the self-pay contribution rates applicable to Continuation Coverage. Contact the Fund Office to obtain current rate information. Under the law, the cost cannot exceed 102% of the cost to the Plan to cover similarly situated individuals for such period. If your coverage is extended due to disability the Plan may charge up to 150% of the cost to the Plan during the 11-month disability extension.

You do not have to show that you are insurable to choose Continuation Coverage. However, you will have to pay the cost of your Continuation Coverage.

A grace period of 45 days will be allowed for payment of the Continuation Coverage premium prior to the date of election and a grace period of 30 days will be allowed for payment of each subsequent Continuation Coverage premium. If the first premium

payment is not postmarked or received by the end of the 45-day grace period, Continuation Coverage will not take effect and the right to Continuation Coverage is forfeited. If any subsequent payment is not postmarked or received by the end of the 30-day grace period, Continuation Coverage will be terminated as of the end of the period for which the last timely payment was received and will not be reinstated.

Continuation Coverage premium payments are required in full each month, however if a timely payment is made in an amount that is not significantly less than the amount required, you will be notified and will have 30 days to pay the deficient amount due. This 30-day period will be measured from the original payment due date or the date of the notice, whichever is later.

If you have any questions about the law, please contact the International Association of Sheet Metal, Air, Rail and Transportation Workers ("SMART") Local Union No. 36 Welfare Fund, 2319 Chouteau Avenue, Suite 300, St. Louis, Missouri 63103.

Also, if you changed marital status, or you or your spouse have changed addresses please notify the Fund at the above address.

Trade Adjustment Assistance. The Trade Act of 2002 and the Trade Preferences Extension Act of 2015 created a tax credit for certain individuals who became eligible for Trade Adjustment Assistance (eligible individuals). If you are or become eligible for Trade Adjustment Assistance (TAA) benefits and do not elect COBRA Coverage during the regular COBRA election period, you may qualify for a Second Election Period of 60 days after receiving your TAA award. Under these tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA coverage. If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at http://www.doleta.gov/tradeact/2002act_index.cfm and information about the Trade Preferences Extension Act of 2015 can be found at various US government websites.

3.15 FAMILY MEDICAL LEAVE ACT (FMLA) OF 1993

Eligibility for leave under the Act is determined by your Employer. If you are eligible you may take up to 12 weeks annually of unpaid leave in the following circumstances:

(a) The serious health condition of Employee
(b) To care for Employee's child after birth or placement for adoption or foster care;
(c) To care for the Employee's spouse, child, or parent who has a serious health condition; or
(d) A qualifying exigency because the Employee's spouse, child, or parent is on active duty or is notified of an impending call to active duty status in support of a

contingency military operation as either a member of the Reserve component of the Armed Forces or as a retired member of the Regular Armed Forces of the U.S. For purposes of this provision a child is defined as the Employee's biological, adopted, or foster child, stepchild, legal ward, or child for whom the employee stood in loco parentis.

The FMLA also allows an Employee to take up to 26 weeks of unpaid leave during a 12-month period to care for a Service member. The service member must be:

(a) The Employee's spouse, child, parent, or next-of-kin who is a current member of the U.S. Armed Forces or National Guard;
(b) Suffering from a serious illness or injury incurred in the line of duty while in military service that renders him or her unfit to perform the duties of his or her office, grade, rank, or rating; and
(c) Undergoing medical treatment, recuperation, or therapy or being treated on an outpatient basis, or on the temporary disability list.

If you are granted FMLA leave your Employer is required to make contributions to the Welfare Plan for the time that you would have worked for the Employer if you were not on leave.

If you believe your leave is covered by FMLA you should contact your Employer. Most Employers and Members of the SMART Local Union No. 36 Welfare Fund do not qualify for this leave.

ARTICLE IV DEATH BENEFIT AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT
Class I, II, III & V Members
Does Not Apply to COBRA Members or Retirees

Life and Accidental Death and Dismemberment benefits are insured through an insurance policy. Payment of benefits is subject to all terms of the insurance policy, see information attached as an appendix.

4.1 MEMBERS ELIGIBLE AND BASIS FOR BENEFITS

A Class I, II, III or IV Member as defined in Sec. 2.3 on page 14 (or in the case of death, the Member's beneficiary) shall be entitled to benefits in the event of accidental or natural death or dismemberment based on the rules in this Article and the insurance policy.

The beneficiary of a Dependent of a Class I, II, III or IV Member shall be entitled to benefits in the event of the accidental or natural death of the Dependent.

4.2 SCHEDULE OF BENEFITS

A. Death Benefit

For Member	$30,000
For dependent spouse	$15,000
For dependent child as defined in insurance policy (unmarried and ages 14 days to 26 years)	$ 5,000

B. Accidental Death and Dismemberment (Member only)

For loss of:	
Life (in addition to Death benefit)	$30,000
Both hands	$30,000
Both feet	
Sight of both eyes	
Speech and Hearing in both ears	
Quadriplegia	
3rd degree burns - 75% or more of body	
One hand	$15,000
One foot	
Sight of one eye	
Speech or Hearing in both ears	
Paraplegia or hemiplegia	
3rd degree burns – 50-74% of body	

Thumb & index finger same hand uniplegia	$7,500

Loss of hands and feet shall mean loss by severance at or above the wrist or ankle, and loss of sight shall mean total and irrecoverable loss of sight.

If a Member dies from natural causes (i.e. not an accidental death) the policy pays the death benefit. If a Member dies from an accidental death then the policy pays the death benefit and the Accidental Death (AD&D Loss of Life) benefit, a total of $60,000.

In addition to the Death and AD&D benefits, the insurance policy provides supplemental benefits that apply only in certain specific circumstances. These benefits include (see appendix for more information):

- Accelerated life insurance which allows you to get a benefit during a terminal illness in lieu of part of the life insurance benefit (Members and spouses only).
- Education and child care benefits when there is an accidental death (Members only).
- Additional benefit for using seat belts and air bags.
- Coma benefit.
- Repatriation of Remains.
- Continuation of Policy.

ARTICLE V ACCIDENT AND SICKNESS BENEFITS FOR MEMBERS

5.1 MEMBERS ELIGIBLE AND BASIS FOR BENEFITS

A Member of Class I (Active Member), II (Administrative Member), III (Owner-Member), or V (Self-pay Member) as defined in Sec. 2.3, on page 14, shall be entitled to benefits in the event of the inability to perform the duties of his regular occupation due to accident or sickness occurring while he is eligible for such benefit.

The benefits apply only to a period of disability, which commences while the Member has active coverage in the Plan and the benefits continue only so long as the Member remains eligible for this benefit.

A Member eligible for the Accident and Sickness Benefits may be eligible for credits towards eligibility based on the disability as set out in Sec. 3.7 on page 28.

5.2 AMOUNT OF BENEFIT

The benefit shall be in the amount of seventy dollars ($70) per usual working day (Monday through Friday, excluding holidays) to a maximum of 5 days per week, or $350 weekly, payable for a maximum of one hundred seventy (170) usual working days. Once Long Term Disability benefits under a Sheet Metal Pension Plan commence then Accident & Sickness Benefits cease.

There shall be a five (5) working day waiting period for the commencement of such benefits in event of accident, or sickness. House confinement is not required, although the Member must be unable to perform each and every duty pertaining to such Member's usual occupation.

5.3 TRUSTEES TO DETERMINE WHEN BENEFITS ARE PAYABLE

The Trustees may require such evidence of qualification for benefits as they deem necessary.

5.4 SUCCESSIVE DISABILITIES

A period of new disability may begin:

If the later disability is the same condition or related to the previous disability:	After completion of 10 consecutive working days (75 hours) of full-time active work with an Employer
If the later disability is entirely unrelated to the previous disability:	After return to full-time active work with an Employer (1 full-time day)

For the purposes of this Accident and Sickness Benefit, benefits are only payable for a successive disability if, after the first disability, the Member performed work for which contributions have been paid to the Fund. Continuation of coverage by self-payment, payment from SASMI or the Equality Fund, and continuation benefits for disabled members are not considered active work for eligibility for Accident and Sickness Benefits for a successive disability.

5.5 EXCLUSIONS

The Accident and Sickness Benefits are not payable for any disability:

(a) Due to an injury or illness covered by Worker's Compensation or similar law whether or not the Employee applies for or receives benefits under such law (see Sec. 7.5(29). The Fund may pay Accident and Sickness benefits upon receipt of an acceptable subrogation agreement with the Member and the Member's attorney.
(b) Due to an injury or illness where there is third party liability and the Fund has a subrogation right to recovery for medical claims (see Article XIV on page 93). The Fund may pay Accident and Sickness benefits upon receipt of an acceptable subrogation agreement with the Member and, if applicable, the Member's attorney.
(c) Due to an injury or illness coverage for which is excluded by the Plan as an Extreme Sport or Professional Athletic Event as defined in Sec. 7.5(31) on page 64, or which results, directly or indirectly, from or during the commission of a grossly reckless, willful, or drug or alcohol induced act that constitutes a felony or otherwise is excluded under Sec. 7.5(30) on page 64.
(d) Due to an injury or illness whose diagnosis or treatment is excluded or not covered by the Plan.
(e) During any period when the Member is not treated by and under the care of a Physician.

5.6 WEEKLY PAYMENTS

Subject to the Fund receiving proof of claim acceptable to the Trustees, the benefits will be paid to the Member each week during any period of disability for which such benefits are payable.

5.7 TERMINATION OF ELIGIBILITY

A Member's eligibility for Accident and Sickness Benefits will automatically terminate if he ceases to be a Member of a class eligible for the benefit.

When a Member eligible for this benefit enters active duty in the armed services of any country, coverage for this benefit will terminate; provided, however, that where a Member of a reserve component of the U.S. armed services is called to active duty for a

training period not exceeding one month, such duty shall not be considered active duty under this clause.

5.8 SOCIAL SECURITY OFFSET

The Plan will offset benefits by amounts paid or due from Social Security Disability and will require participants to sign an agreement to repay the Plan for any amounts later recovered for the same period from Social Security Disability payments.

5.9 TAX ISSUES

Accident and Sickness Benefits are taxable and taxes will be withheld as required by law. Information about benefits and taxes will be reported to your last contributing employer who will report it on your W-2.

5.10 NO ASSIGNMENT

Except to the extent required by law, a Member's Accident and Sickness Benefits are non-assignable and are not subject to execution, attachment, garnishment, or levy by any creditor of the Member. However, the benefit is subject to reduction by any amount the Member or any of his Qualified Dependents may owe the Fund.

5.11 AMOUNTS PAID IN ERROR

Any amounts paid in error or because of a fraudulent application, must be repaid to the Fund and the Trustees reserve the right to recuperate any amount paid in error from future benefits.

ARTICLE VI COMPREHENSIVE MEDICAL BENEFITS – GENERAL INFORMATION

Important: Read this Article carefully, along with Articles VII (Comprehensive Medical Benefits – Covered Charges and Exclusions), Article VIII (Mental Health and Substance Use Disorder (MHSUD) charges, Article IX (Prescription Coverage), Article X (Hearing Aids and Vision Benefits), Article XI (Dental Benefits), and Article XII (Retired Member Benefits).

6.1 AUTOMATIC ASSIGNMENT OF BENEFITS

Benefits will be automatically paid to the provider of services upon receipt of an approved itemized bill unless proof is submitted with the bill indicating that the bill has been paid by the Member or Qualified Dependent, in which case benefits will be paid directly to the Member.

6.2 DEDUCTIBLE AMOUNT

(the deductible amounts for each class of Members are set out in the schedules at the beginning of this Summary Plan Description)

(1) The Plan has an embedded deductible. This means that the deductible amount is applicable to each Member and each Qualified Dependent who qualifies for benefits during any twelve-month period commencing January 1 and ending December 31 of the same year. Once a Member or dependent meets the individual deductible the deductible is satisfied for that person. If the family deductible is satisfied for that year; the individual deductible is satisfied for any additional family members for the rest of that year.

(2) The deductible is applied to inpatient stays, outpatient surgery, and emergency room visits under the Plan. The deductible is also applied to office visits to non-PPO providers.

(3) An amount applied to the Tier 1 (in-network), Tier 2 (out-of-area), or Tier 3 (non-network) deductible will be applied to all three deductibles up to each tier's total deductible. Amounts applied to the Tier 2 and Tier 3 deductibles after the Tier 1 (or Tier 2) deductible is met do not apply to the Tier 1 (or Tier 2) out-of-pocket maximums.

(4) If a Member or spouse participates in the Plan's prenatal program and completes the case management requirements of that program, the Tier 1 (in-network) and Tier 2 calendar year deductibles will be waived for the mother and newborn infant. Any deductible amounts that are waived under this provision will be applied towards the family deductible for that calendar year.

6.3 INDIVIDUAL MAXIMUM BENEFIT

The Plan does not have a maximum limit on either lifetime or annual amounts that the Plan will pay for essential medical benefits

The elimination of the annual benefit maximum applies only to essential medical benefits. Dental and vision coverage still have benefit maximums as do the Accident and Sickness and AD&D benefits.

6.4 WHEN EXPENSES INCURRED

A medical expense is incurred on the date when the Member or Qualified Dependent received or is furnished the services or supplies in connection with which such expense is incurred. A claim is not filed, however, until the Plan is notified of the charges in manner acceptable to the Fund. See Article XVI beginning on page 98. No benefits are payable for expenses incurred while a Member or Qualified Dependent is not covered under the Plan.

6.5 INDIVIDUAL/FAMILY OUT-OF-POCKET MAXIMUM

(the Out-of-Pocket Maximums for each class of Members are set out in the schedules at the beginning of this Summary Plan Description)

There is a maximum amount of Tier One (network), and Tier Two medical and prescription drug expense payable by any individual Member or Qualified Dependent during a Plan year. There is also a maximum amount payable by a Family during a Plan year. This is a single out-of-pocket maximum for both Tier One and Tier Two expenses. All deductibles, co-payments and co-insurance apply to the applicable medical and prescription drug maximums.

The Plan has an embedded Out-of-Pocket maximum. This means that the Out-of-Pocket maximum amount is applicable to each Member and each Qualified Dependent who qualifies for benefits during any twelve-month period commencing January 1 and ending December 31 of the same year. Once a Member or dependent meets the individual Out-of-Pocket maximum the Out-of-Pocket maximum is satisfied for that person. If the family Out-of-Pocket maximum is satisfied for that year; the individual Out-of-Pocket maximum is satisfied for any additional family members for the rest of that year.

After the applicable maximum amount has been paid by the individual or family, the Plan will pay medical expenses at 100% subject to any benefit limitations. Amounts not covered by the Plan (for example, amounts above the Usual, Customary and Reasonable

Charge, see Sec. 2.23 on page 23) do not apply to the maximums and will not be paid by the Plan after the maximum is met.

There is no maximum for non-network charges.

6.6 PREDETERMINATION

IMPORTANT: The predetermination requirement in this section applies to medical expenses described in this Article and Article VII as well as Mental Health and Substance Use Disorder treatment expenses (Article VIII beginning on page 65).

To assist you in determining whether charges for a service or supply are covered under the plan before you commit to receiving the service or supply, the Welfare Fund requires Predetermination for medical necessity and appropriateness through Coventry, E4 Health, or other independent medical consultants.

After a determination of Medical Necessity, the Fund Office will review the claim for eligibility and coverage when it is submitted after services are rendered. Thus, a claim for Medically Necessary services could be denied on other grounds. To determine the patient's eligibility and whether the service or supply is covered or excluded under the terms of the Plan, contact the Fund Office. None of the Plan's medical consultants, including Coventry and E4 Health have the authority to determine whether the service or supply is covered or to what extent benefits are payable.

Neither the Plan nor any independent medical consultant, including Coventry and E4 Health, will make any decisions regarding your medical treatment or the receipt of health care services. You should make all final decisions about your medical care after consultation with your Physician.

If you have any questions about the Predetermination or who to contact call the Fund Office at 314-652-8175.

(a) Surgical Procedures, Other Outpatient Procedures and Home Health Care: To get a predetermination of whether a scheduled surgical procedure, other outpatient procedure or home health care service is considered Medically Necessary and appropriate, call Coventry.

(b) Hospital Admissions: Before you or a Qualified Dependent enters a Hospital for a non-emergency inpatient admission, your Physician or Hospital may contact Coventry at 800-546-4603 for a pre-determination of Medical Necessity and appropriateness. You and your Physician will be notified of the determination. To ensure that predetermination has been requested, the Member should contact the Fund Office.

(c) Concurrent Review: Once you are admitted to a Hospital, Coventry's nurses will perform periodic reviews of your medical progress and will check with your Physician and Hospital. If Coventry approves the continued stay, your claim will not be denied on the basis of the length of stay.

In the event of an emergency admission, your Physician should contact Coventry/CMR within 48 hours following the admission to start the concurrent review program and should contact the Fund Office for a determination of Medical Necessity and appropriateness.

(d) Mental Health and Substance Use Disorder (MHSUD) Treatment: Before you or a family member undergo any type of treatment, including hospitalization, for mental health or substance use disorder health care, you may contact E4 Health at (800) 765-9124 to obtain a predetermination of the Medical Necessity and appropriateness of the proposed treatment. Coventry does not perform Mental Health and Substance Use Disorder predeterminations for the Plan.

In the event of an emergency admission for treatment for a mental health or substance use disorder health problem, you or your Physician may contact E4 Health within 48 hours following the admission to participate in the concurrent review program.

(e) Review of Predetermination: If your Physician disagrees with a predetermination decision that hospitalization, length of stay, surgery or outpatient procedure is not Medically Necessary, your Physician should contact Coventry at (800) 546-4603 or E4 Health at (800) 765-9124 to initiate a review. Because the Plan does not recognize a claim until after the services are rendered, there is no appeal procedure for denial of a predetermination. If you disagree with the predetermination decision, you may obtain the services and, when the claim is submitted after the services have been performed; the claim will be reviewed by the Plan without deference to the negative predetermination.

ARTICLE VII COMPREHENSIVE MEDICAL BENEFITS – COVERED CHARGES AND EXCLUSIONS

(See Articles VIII - XI for Prescription Drug, MHSUD, Dental, Hearing Aid and Vision Benefits)

7.1 COVERED AND EXCLUDED CHARGES – GENERAL INFORMATION

Covered charges are charges made for covered Hospital expenses or covered medical expenses, subject to all of the following:

(1) The charge must be for a service or supply prescribed by a Physician.

(2) The charge must be for a service or supply which is necessary in connection with the diagnosis or therapeutic treatment of an injury or sickness or covered by the Wellness and Preventive Benefit. In determining whether a service or supply, what portion of a service or supply, or what length of Hospital confinement or amount of treatment is included in this definition, a service or supply must be commonly and customarily recognized by the Physician's profession in the United States as appropriate and reasonably necessary treatment of the diagnosed injury or sickness.

(3) The charge must not be educational, Experimental, or Investigative in nature, nor, except as set out below, provided primarily for research. It must neither be for custodial care nor maintenance care. All services must be received in the most cost-efficient manner and type of setting that can be used safely (for example, in the Physician's office instead of in a Hospital).

Charges for "routine patient costs" incurred by a "qualifying individual" who is participating in an "approved clinical trial" will be covered in the same manner as if the charge had been incurred without the trial. For purposes of this benefit,

a) A "qualified individual" is someone who is eligible to participate in an "approved clinical trial" and either the individual's doctor has concluded that participation is appropriate or the participant provides medical and scientific information establishing that his or her participation is appropriate.

b) "Routine patient costs" are all medically necessary health care provided to the individual for purposes of the trial, consistent with a plan's medical coverage, and services that would be covered for those not enrolled in a clinical trial. Such services include those rendered by a physician, diagnostic or laboratory tests, and other services provided during the course of treatment for a condition or one of its complications that are consistent with the usual and customary standard of care. Routine patient costs do not include the actual device, equipment or drug that is being studied. Also excluded are: items and services that are provided solely to satisfy data collection and analysis needs that are not used in direct clinical management of the patient; or a service that is clearly inconsistent with the widely accepted and established standards of care for a particular disease or condition.

c) An "approved clinical trial" is a Phase I, II, III or IV clinical trial conducted in connection with the prevention, diagnosis or treatment of cancer or other life-threatening diseases or conditions or other condition described in the ACA. A life-threatening condition is defined as any disease from which the likelihood of death is probable unless the course of the disease is interrupted. The trial must be approved or sponsored by a the National Institutes of Health, the Centers for Medicare & Medicaid Services, the Food and Drug Administration (FDA) or other federal agency.

(4) Charges made by a Tier One or Wrap network provider must not exceed the applicable negotiated fee. Non-Network and Out-of-Area provider charges must not exceed the Usual, Customary, and Reasonable charges

(5) Charges for services rendered by a Physician Assistant will be covered provided that:
   a) The Physician Assistant is employed by a licensed Physician or by a facility which also employs supervisory Physician(s);
   b) The services are rendered under the supervision of the employing Physician or facility;
   c) The employing Physician or facility and the Physician Assistant are both network providers; and
   d) The services are rendered pursuant to a supervision agreement specific to the diagnosis and treatment plan of the supervising Physician.

   Covered Physician Assistant services include taking patient histories; performing physical examinations; performing routine lab, screening, and therapeutic procedures; and assisting the supervising Physician. If a service would not be covered when performed by a Physician it will not be covered when performed by a Physician Assistant.

(6) The service or supply must not be excluded by any provision of this Plan. See Sec. 7.5 beginning on page 61 for a list of some exclusions. However, in the event of serious illness or injury, the Trustees have the discretion to approve an alternative treatment, not otherwise covered by the Plan if such alternative treatment is supported by medical evidence and is less costly than benefits provided under the terms of this Plan. Alternative treatment will not be considered unless recommended by either the treating Physician or case manager. Ordinarily, approval of non-covered benefits will be in place of confinement in a Hospital or other institution where it is more cost effective to provide such non-covered benefits than to provide benefits under the Plan. Examples of some expenses that may be covered under this section are: additional skilled nursing facility care or home health care services beyond those otherwise covered by the Plan.

Alternative care will be reviewed on the merits of each individual case and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that covered person or any other covered person.

(7) Charges incurred for non-emergency medical care rendered outside the United States will only be covered if preauthorized. Emergency and preauthorized charges will be covered as any other claim.

7.2 MEDICAL EXPENSES PAYABLE TO A HOSPITAL

If the Member, or one of his Qualified Dependents incurs covered charges as a result of treatment by, or confinement in, a Hospital, the Trustees will, subject to all the terms of this Plan, pay the following benefits:

(1) Benefit Percentage Payable. After the Member or Qualified Dependent pays the applicable deductible and copayment shown in the Schedule of Benefits, benefits are payable as set out in the Schedule of Benefits. The percent paid by the Plan is the highest when an in-network (CMR) provider is used. If you cannot use an in-network CMR provider the Plan pays a higher percentage if you use a FirstHealth (FH) provider or come under the Out–of-Area benefit than if you use a non-network provider. The Plan pays the least if you use a non-network provider.

(2) Limited to Semi-Private Room Charge. Benefits paid for room and board charges will not exceed the daily semi-private room and board rates for that Hospital.

If there is no semi-private room rate or the patient's medical condition requires patient isolation, then the private room rate or isolation room rate will be paid.

Benefits in Intensive Care Units will be paid at the percentages applicable to the facility and will not be subject to the semi-private room rates.

(3) Outpatient Testing. Laboratory and x-ray charges are paid at the applicable rates shown in the Schedule of Benefits.

(4) Maternal and Newborn Care. The Plan will not restrict benefits for any Hospital stay in connection with childbirth for the mother or newborn child, following a vaginal delivery to less than 48 hours, or to less than 96 hours in the case of a cesarean section. The mother's or newborn's provider, after consulting with the mother, may discharge the mother or her newborn before the expiration of the 48-hour (or 96-hour as applicable) period.

(5) Skilled Nursing Facility Benefit. Subject to the applicable deductible and co-payments, the Plan covers the reasonable charges made by a Skilled Nursing Facility for the first 60 days of its room and board accommodations and for supplies and

services necessary in the treatment of the Member or a Qualified Dependent, provided: (1) such individual is confined as a registered bed patient on the certification of the treating Physician that such confinement is necessary, and (2) such confinement commences within seven (7) days after a period of at least five (5) days of hospital confinement covered by this plan. All periods of confinement in a Skilled Nursing Facility during any disability will be considered one period of confinement for the purpose of the 60-day limit. No other confinement will be covered unless it is for a new disabling condition after there has been a complete recovery from the first condition, release from confinement, and return to work or, in the case of a non-working Qualified Dependent, return to normal activities.

7.3 MEDICAL EXPENSES OTHER THAN THOSE PAYABLE TO A HOSPITAL

(NOTE: Also read exclusions in this Article and throughout this SPD.)

If a Member or Qualified Dependent incurs covered medical expenses, the Plan will pay subject to the terms of this Plan for the following services:

(1) Diagnosis, surgery or treatment by a Physician.

(2) Services of a licensed dentist for treatment of fractures and dislocation of the jaw and for cutting operations in the mouth to correct damages caused by accidental injury.

(3) Professional services of a Registered Nurse or, if none is available, of a Licensed Practical Nurse who does not ordinarily live in the Member's home and who is not a Close Relative (see Sec. 2.5 on page 15) of the Member or of any Qualified Dependent. Nursing services outside a Hospital shall be covered for no more than 30 days immediately following Hospital confinement, unless a written application for other nursing services based on special need has been pre-approved by Coventry/CMR. Such requests should be made as soon as it is known that a longer period of nursing may be needed.

(4) Professional services for the administration of anesthesia.

(5) Professional services of a radiologist or laboratory services for diagnosis or treatment.

(6) Transportation by professional ambulance to and from a Hospital in cases where, for medical reasons, transportation cannot be by private automobile or common carrier.

(7) Durable Medical Equipment.

To be covered, Durable Medical Equipment must be prescribed by a Physician solely for the therapeutic care and treatment of a covered individual and must not be an item generally usable for recreation, comfort, or non-therapeutic purposes. Charges are limited to the cost of rental up to the purchase price. If the item cannot be rented the Plan will pay the usual, customary and reasonable purchase price. Examples of Durable Medical Equipment include oxygen tanks and supplies, for use outside of a medical facility; braces, crutches, prostheses; wheelchairs; and hospital beds.

In connection with a "CPAP" device, the Plan will pay 100% without a deductible when the device is purchased through a vendor approved by the Plan Administrator. There is no benefit for CPAP devices purchased from a provider other than one approved by the Plan Administrator.

The Plan covers wigs or hairpieces when prescribed to replace the loss of hair as a consequence of medical treatment, for example hair loss as a result of chemotherapy. The Plan does not cover wigs or hairpieces to replace hair loss as a result of normal balding.

(8) Orthotics, up to one pair per calendar year.

(9) Glucose monitoring devices (Glucometers) and testing supplies for diabetic conditions. In most cases these items are covered under the prescription drug benefit. For individuals using insulin infusion pumps, however, the devices and supplies may be covered under both medical and prescription drug benefits and the benefit level may be different. Contact the Fund Office for assistance.

(10) Hospital, surgical, and medical services and supplies furnished to the Member or Qualified Dependent, approved by a Physician or other professional acting within the scope of his or her professional license.

(11) Services of a podiatrist for surgical procedures. Trimming of nails, calluses, or similar services are only covered in situations where it would be unsafe if someone other than a doctor performs them because of a serious medical condition affecting the whole body (such as diabetes) or if there are signs of fungus in the nails, and there is pain, infection, or problems walking.

(12) Charges by a Hospice for the following services and supplies to the extent they are prescribed by a licensed Physician for a terminally ill patient:

a. palliative care,

b. home health care services of a Registered Nurse, Licensed Practical Nurse or a home health aide working under the supervision of a Registered Nurse or Licensed Practical Nurse who does not ordinarily live in the Member's home and who is not a Close Relative of the Member or any Qualified Dependent,

c. nutrition service,

d. counseling and social support services by a licensed social worker, and

e. coverage of services provided to assist the patient's family with the day-to-day care of the patient, including such things as bathing, feeding and turning. Other custodial care, such as housekeeping and transportation services are not covered.

(13) Medically necessary, non-experimental organ and tissue transplants are covered under the Plan for Eligible Members and Qualified Dependents.

Benefits for expenses incurred in conjunction with the covered transplant of a human organ or tissue will be payable in accordance with the following rules:

	Situation		Coverage
i.	The recipient is covered under the plan and receives the organ from a cadaver.		The recipient's expenses, including the charge for the organ, are covered.
ii.	The recipient is covered under the plan and receives the organ from an organ bank.		The recipient's expenses, including the charge for the organ, are covered.
iii.	The recipient and the donor are both covered under this Plan.		The expenses of both are covered under the recipient's claim. Eligible donor's charges are limited to $20,000/transplant.
iv.	The recipient is covered under this Plan but the donor is not covered under this or any other plan.		The expenses of both are covered under the recipient's claim. Eligible donor's charges are limited to $20,000/transplant.
v.	The recipient is covered under this Plan and the donor is covered under another plan.		Only the recipient's expenses are covered.
vi.	The donor is covered under the plan, but the recipient is not.		The expenses of neither are covered unless the recipient is a parent, sibling or child of the Member or Qualified Dependent, in which case the expenses of the donor are covered.

Organ Transplant Expenses Include: pre-transplant testing and consultation; all services and supplies incurred for the transplant procedure; postoperative care in the Hospital (inpatient or outpatient); extended care in a facility or at home; pharmaceuticals and their administration (only while hospitalized), including but not limited to high dose chemotherapy or anti-rejection drugs; durable medical equipment; and, to the extent provided above, the donor's expenses. The percentages paid on these services are determined by the provider's participation in the plan's provider network.

The Plan may use an independent Transplant Network in addition to, or in place of, Coventry/CMR to obtain the best care at the lowest cost. Therefore, the Trustees strongly encourage covered individuals to contact the Fund Office before undergoing any inpatient procedure, including an organ transplant procedure. If you do not contact the Fund Office, you run the risk of discovering after expenses have been incurred that the procedure is not covered by the plan.

(14) Services of a licensed speech therapist under direct supervision of a Physician for restorative speech therapy for speech loss or impairment due to an illness or injury, or due to surgery performed on account of an illness or injury. Any other speech therapy treatment, including for habilitative or educational purposes, will not be covered.

(15) Professional services of a licensed physical or occupational therapist as pre-authorized as medically necessary by Coventry/CMR.

(16) A Member or Qualified Dependent who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, is also covered for:

a. all stages of reconstruction of the breast on which the mastectomy has been performed;

b. surgery and reconstruction of the other breast to produce a symmetrical appearance; and

c. prostheses and physical complications of mastectomy, including lymphedemas (fluid retention and swelling related to the lymph nodes);

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

Coverage is subject to any deductibles, co-payments, pre-certification, pre-authorization or other coverage requirements that apply under the Plan for similar types of coverage.

(17) Educational and Training services and supplies as follows:

a. Nutritional counseling for diabetics but only if prescribed by a Physician and performed by a registered dietitian;

b. Training visits for patients who require self-injections of prescribed medication;

c. Vision training to correct strabismus, myofunctional therapy for orofacial muscle imbalance; and

d. Biofeedback therapy.

Covered Charges will be limited to three educational/training sessions per lifetime per condition.

(18) Charges for the diagnosis and treatment of infertility will be payable as follows:

a. work-up and diagnostic tests to evaluate the cause of infertility are covered in the same manner as any other illness;

b. surgery to open tubes which are closed due to disease are covered in the same manner as any other illness; and

c. drug therapy to treat infertility (including Physician visits, consultations, sonograms and pregnancy tests) is covered at 50% subject to the applicable Calendar Year Deductible, up to a maximum benefit of $2,500 for each attempted pregnancy. The 50% not paid by the plan and any amounts in excess of the $2,500 maximum benefit do not count toward the Deductible or Out-of-Pocket Maximum.

See Sec. 7.5(28) on page 63 for specific exclusions.

(19) Home care charges made by a Hospital or by a Home Health Agency after confinement in a Hospital or convalescent nursing home, subject to the following:

a. a Physician must submit a treatment plan to the Fund Office that includes the type of services to be provided and a letter of Medical Necessity that medical care is necessary for treating the illness which caused the confinement; and

b. the medical care must consist of care by one or more of the following, who does not have the same legal residence as, and is not a Close Relative of the Member or Qualified Dependent:

(i) A Registered Nurse or Licensed Practical Nurse, or a medical professional under the supervision of a nurse;
(ii) A home health aide; or
(iii) A licensed occupational therapist.

(20) Treatment, including Hospital, surgical and medical charges, related to a congenital or developmental abnormality provided the treatment, or plastic and reconstructive surgery is for the restoration of bodily function, or the correction of a deformity resulting from disease, injury, or congenital or developmental abnormalities. For the purposes of this benefit, the term treatment does not include cosmetic surgery performed to reshape normal structures of the body to improve appearance or self-esteem.

(21) Chiropractic services. Treatment by a licensed doctor of chiropractic for services within the scope of his or her chiropractic license. Only charges incurred at an in-network CMR or FirstHealth (FH) provider will be covered unless the Out-of-Area benefit applies. The co-payment for chiropractic office visits is the same as the co-payment for primary care provider office visit.

(22) Specialty Drugs are covered under the medical coverage benefits of the Plan not the prescription drug benefits.

LDI is the Fund's exclusive Specialty Network and Specialty drugs must be obtained through LDI. If you obtain a specialty drug from another source, including your Physician’s office or Hospital, the Plan will only cover the cost if obtaining the medication from that source was pre-authorized and then coverage will be limited to the amount that would have been covered if purchased through LDI.

Any amounts paid to a provider other than the LDI Specialty Pharmacy above the amount that LDI would pay are not a covered charge and do not apply to any out of pocket maximums. In addition, the amounts paid to a provider other than the LDI specialty pharmacy will be subject to the Plan's Deductible and Out-of-Pocket Maximum rules for out-of-network providers.

a. Out-of-Pocket Maximum: The Out-of-pocket charges for Specialty Drugs apply to both the specialty drug and general Medical annual Out-of-Pocket Maximums.

b. The plan will pay the first 30% of the cost of a specialty drug obtained in-network or out-of-network. The Fund will then assist the individual is applying for any available co-pay assistance and coupons from pharmaceutical manufacturers and for payment from other plans covering the individual.

c. For specialty drugs obtained in-network (through the LDI Specialty Pharmacy):

(i) If payment from other sources is received the Plan will pay the remaining cost of the medication after those third party payments are applied with no amount due from the individual.
(ii) If there is no payment available from other sources the individual will only be responsible for the remaining cost (after the initial 30% paid by the Plan) up to a maximum of the lesser of the applicable medical Out-of-Pocket Maximum or the annual $500 in-network specialty drugs Out-of-Pocket Maximum.

d. For specialty medications obtained through a source other than the LDI Specialty Pharmacy the individual is responsible for any amounts above the 30% that are not paid by a third party.

(23) Treatment of Temporomandibular Joint dysfunction (TMJ), Pre-Authorization Required.

(24) Second Medical Opinion

a. There is no mandatory second medical opinion on most procedures.

b. Although a second opinion is not mandatory, whenever surgery is recommended, you may wish to secure a second opinion from an independent Physician.

c. If the second opinion is not in favor of surgery you may go ahead with surgery or obtain a third opinion. If you want a second, or third, opinion you may ask your attending Physician for a referral or you may contact your local Medical Society. The only qualification for another opinion is that it must be given by a Board Certified Specialist, who is not financially associated with the first (or second) Physician.

d. The Plan will pay 100% of the Usual, Reasonable, and Customary charges for the second (and third, if necessary) Physician's opinion, as well as any required diagnostic tests which are needed for the second (or third) opinion. Before undergoing the same tests, you should ask your attending Physician to send x-rays and test results to the second Physician. Be sure the Physician indicates this is a second opinion on his billing.

7.4 WELLNESS AND PREVENTIVE CARE BENEFITS

(1) Preventive and Wellness Care Generally

Preventive care will be covered at 100% with no deductible and no co-payment as long as provided by a Tier 1, in-network Coventry/CMR provider, or Tier 2, FirstHealth or out-of-area benefit provider.

For purposes of this benefit preventive care includes standard immunizations and those services recommended by the U.S. Preventive Services Task Force at the time the service is provided including, as appropriate for the age and gender of the individual, mammograms, colonoscopies, blood pressure screening, and cholesterol screening. A full list of those services can be obtained from the Fund Office.

(2) Women's Preventive Care

In connection with women's preventive care at least one form of each of the 18 different contraceptive methods will be covered at $0 as required by the Affordable Care Act (ACA). Over the counter contraceptives (OTC) included within the ACA guidance will only be covered at 100% when obtained with a prescription and filled at an in-network pharmacy. The requirements for a prescription and purchase through a pharmacy do not apply to OTC emergency contraception (for example, Plan B OneStep and Next Choice One Dose). The regular Plan rules (prescription or medical) will apply to other forms of contraception (for example, if a generic form of an oral contraceptive is available and the individual wants a brand name then the prescription will be covered the same as any other brand name prescription where a generic is available).

Women's wellness also includes prenatal charges incurred during an Annual Well-Woman Exam, the cost of screening for gestational diabetes, and comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for purchasing breastfeeding equipment (call the Fund Office for information on where to purchase covered breastfeeding equipment). These benefits apply to all female participants and dependents, including daughters.

(3) Weight Loss and Obesity

The Plan covers

a. Screening of children age 6 years and older and all adults for obesity and covers counseling and appropriate behavioral interventions to promote improvement in weight status for adults with a body mass index of 30 kg/m2 or higher.

b. Prescription medication for weight loss as follows:
   - The prescription must be on the Plan's formulary for weight loss medications;
   - **The prescription must be pre-certified** by the Fund's Prescription Drug Manager, LDI;

- Pre-certification must be renewed on a regular basis and a prescription can only be filled for 30 days at a time;

Pre-certification is based on a number of health factors including BMI, the presence of co-morbidities (other diseases related to the obesity such as diabetes) and, for continuation of the medication, a demonstration of weight loss.

A list of prescription medications that will be covered has been developed based on recommendations from the PBM and Case Management. This list is subject to change as new medications are developed and released.

c. Surgery for weight loss and obesity as follows:

- **All surgery must be pre-certified**;
- You must undertake a period of nutritional diet/exercise prior to surgery;
- You must complete pre-surgery testing (for example satisfactory cardiac and psychological evaluations) to establish suitability for surgery.

You must use the Plan's specialty network for weight loss surgery. This network is made up of providers that have a proven track record in surgical treatment of obesity and who have agreed to certain costs (the Plan will cover charges from an out-of-area provider up to the amount that would have been charged by a provider in the specialty provider network).

The Plan's professionals monitor the weight-loss specialty network and the providers are subject to change, so call the Fund Office for information about this benefit.

Except as set out above and in regulations, the Plan excludes services, treatment or supplies for the treatment of obesity and associated illness or injury.

(4) Smoking cessation

The Plan covers up to two in-network counseling sessions of 4 sessions each in a calendar year as well as a number of types of smoking cessation aids. Smoking cessation aids will only be covered if they are FDA approved and when there is a prescription. The items that are covered and the terms of coverage (for example how many times a prescription will be filled in a year) are based on FDA guidelines and are, therefore, subject to change. Contact the Fund Office to find out if a particular smoking cessation aid is covered and the terms of coverage.

7.5 EXCLUSIONS

The covered Hospital and medical expenses in this Article VII and in Articles VIII, IX, X and XI shall not include expenses for the following excluded services, treatment and supplies even if the services, treatments or supplies are Medically Necessary:

(1) Non-network charges are excluded in connection with some benefits, including charges for the following:

a. Wellness and preventive care benefits
b. Hospital out-patient surgery
c. Out-patient surgery centers
d. Chiropractic charges
e. Physician assistant charges

(2) Dental services other than those specified in Sec. 7.3(2) on page 52 and Article XI beginning on page 74. In addition, the Plan does not cover General Anesthesia and facility charges for dental care except when pre-authorized in connection with services rendered to a child under the age of 5 or an individual with a developmental disability.

(3) Cosmetic or plastic surgery that is not Medically Necessary to treat an illness or injury. Plastic and reconstructive surgery is only covered as set out in Sec. 7.3(16) on page 55 for surgery following a mastectomy and 7.3(20) on page 57 for treatment of a congenital or developmental abnormality or for the restoration of bodily function, or for the correction of a deformity resulting from medical or surgical treatment.

(4) Maintenance care or custodial care where medical services are only incidental.

(5) Travel to and from a Hospital or a Physician's office other than the ambulance services specified in Sec. 7.3(6) on page 52.

(6) The excess by which any charge exceeds the applicable negotiated rate or Usual, Customary and Reasonable charge for any medical service or supply, taking into account all the relevant circumstances.

(7) Dependent child's pregnancy, its complications, and related charges except to the extent of coverage of certain charges under the preventive care benefits of the Affordable Care Act.

(8) Chiropractic services beyond the limits allowed in Sec. 7.3(21) on page 57, these limits also apply to other medical services that are similar to chiropractic services.

(9) Medical expenses, or any continuing medical treatment or service not recommended or approved by a Physician or other medical professional acting within the scope of his or her license.

(10) Any elective medical service or treatment that is not Medically Necessary except as specifically provided for as a benefit by the Plan.

(11) Medical supplies or equipment other than those used as a patient in a Hospital under Sec. 7.2 beginning on page 51 or those named specifically in Sec. 7.3 beginning on page 52, examples of exclusions: heating pads, air purifiers, and exercise devices.

(12) Acupuncture treatment.

(13) Eye exams and corrective lenses, except as provided for in Article X beginning on page 72.

(14) Personal items provided to a Hospital inpatient including, but not limited to, telephones, television, lotion, tissue, toothpaste, toothbrush, shaving devices, and footwear.

(15) Charges for completion of insurance forms or Physician patient phone consultation charges.

(16) Any service or supply which is not commonly and customarily recognized by the Physician's profession in the United States as appropriate and reasonably necessary treatment of diagnosed injury or illness.

(17) Any service or supply which is Experimental, Investigative or provided primarily for research. This exclusion does not apply to "routine patient costs" incurred by a "qualified individual" in connection with participation in an "approved clinical trial." See Sec. 7.1(3) on page 49 for coverage in connection with a clinical trial. Contact the Fund Office before incurring treatment if there is any doubt about coverage.

(18) Any service or supply excluded by any provision of this Plan.

(19) All services and supplies directly related to self-inflicted injuries or illnesses sustained unless such injury or illness results from a medical condition (including both physical and mental conditions); it is generally presumed that any self-inflicted injury sustained while insane is the result of a medical condition and will be covered.

(20) Charges that would not have been made if this benefit plan did not exist.

(21) Charges that neither the Member nor his Qualified Dependent is required to pay.

(22) Charges for services or supplies which are furnished, paid for or otherwise provided for by reason of past or present service of any person in the armed forces or any other governmental service.

(23) Charges for medical services provided by a Close Relative (see Sec. 2.5 on page 15) for the definition of Close Relative.

(24) Charges for which the Fund has requested additional information including proof of eligibility, medical records and information about third party liability and the requested information has not been provided to the Fund in a timely manner.

(25) Any payment or expense caused by or resulting from war, declared or undeclared, invasion, acts of foreign enemies, hostilities, civil war, rebellion, insurrection, military or usurped power, or martial law or confiscation by order of any government or public authority.

(26) Speech Therapy is an educational service and is not covered, except as provided in Sec. 7.3(14) on page 55.

(27) Educational and training services and supplies except as specifically set out in Sec. 7.3(17) on page 56.

(28) Infertility Treatment except as provided in Sec. 7.3(18) on page 56. No coverage is provided for:

(i) Reversal of Voluntary Sterilization (Vasectomy, Tubal Ligation, etc);
(ii) Artificial Insemination;
(iii) In Vitro Fertilization; or
(iv) Surrogate Parenthood.

(29) None of the benefits under this Plan, including Accident and Sickness Benefits, are payable where the death, dismemberment, disability, Hospital, or medical expense results from an occupational injury, sickness or disease. Such injury, sickness or disease includes, but is not limited to, one which is covered by any Workers' Compensation, occupational disease, or similar law, or would be covered if such law applied. Failure to file a timely claim for benefits under any such law does not mean that benefits are payable from this Fund. If a person is performing work which would be covered by Workers' Compensation insurance, but because of his own actions (for example, use of drugs, a safety violation, or failure to comply with Workers' Compensation procedures) his claim is denied, no coverage will be provided by this Fund. The Fund may pay medical benefits, in accordance with the terms of the plan, upon receipt of an acceptable

subrogation agreement with the Member or Dependent and, if applicable, the Member or Dependent's attorney.

(30) The Fund does not cover charges for treatment of an injury or illness resulting directly or indirectly from or occurring during the commission by the injured individual of **a grossly reckless, willful, or drug- or alcohol-induced** act that constitutes a felony, involves violence or a threat of violence, or in which the participant illegally used a firearm, explosive or other weapon likely to cause physical harm, as determined by the Plan and the Trustees in their sole discretion. The lack of conviction or issuance of a citation by a law enforcement body is not conclusive as to whether the charges resulted from an excluded act.

(31) The Fund does not cover charges for treatment of an Injury or Illness resulting directly or indirectly from participation in:

a. Professional sports or athletics, including Injury sustained while participating in (1) any professional or semi-professional sport, contest or competition; or (2) in any organized practice or conditioning program pertaining specifically to such sport, contest or competition. Professional or semi-professional sports, contests and competitions include, but are not limited to:

i. events where the individuals participating receive wages (for example a player for the Gulf Coast League Cardinals Farm Team),

ii. events where a significant number of the individuals competing for a purse or prize are professionals (for example the Dakotas Golf Tournament Tour or an event regulated by The Missouri Office of Athletics), and

iii. events where skilled individuals are demonstrating the sport for money.

A charity competition is generally not a professional contest or competition nor is an event engaged in as part of a hobby or leisure activity.

b. Any sport, athletic, or transient amusement activity which is undertaken for thrill seeking or which exposes the individual to abnormal or extreme risk of injury, sometimes referred to as extreme or hazardous sports. Examples of extreme sports include, but are not limited to, sky diving, heli-skiing, roller derby, and motor-cross racing.

ARTICLE VIII MENTAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT

All Mental Health and Substance Use Disorder benefits are covered the same as any other medical benefit based upon the nature of the provider and the services provided. This Article sets out information specific to the Mental Health and Substance Use Disorder (MHSUD) benefits, the E4 Health network, and the Member Assistance Program (MAP).

8.1 MEMBER ASSISTANCE PROGRAM (MAP) & MHSUD NETWORK

The Welfare Plan has contracted with E4 Health to provide enhanced Member Assistance Program (MAP) benefits separate and apart from the MHSUD Welfare benefits. You may obtain a copy of MAP benefits by contacting the Fund Office or E4 Health.

In addition, E4 Health has established a network for MHSUD HMO providers. While the Welfare Fund Trustees encourage participants and their families to use the MAP, participation in the MAP is not a condition for MHSUD network or non-network benefits.

- MHSUD claims incurred with providers in the either the E4 Health or the CMR networks will be paid at the Plan's Tier One deductibles and copayment rates for medical claims.
- MHSUD claims incurred with FirstHealth network providers will be paid at the Tier Two deductibles and copayment rates for medical claims.
- MHSUD claims incurred outside of the area covered by both the E4 Health and CMR networks will be paid at the Out-Of-Area rate for medical claims.
- MHSUD claims incurred with non-network providers in the area covered by the E4 Health or CMR networks will be paid at the non-network rate for medical claims.

The Welfare Fund encourages Participants and their families to call E4 Health to learn about enhanced MAP benefits and to receive assistance in selecting a MHSUD provider.

8.2 PREDETERMINATION

E4 Health will be making medical necessity determinations for MHSUD and will be providing case management services for large MHSUD claims. Similar to medical claims, the Welfare Plan provides that participants and providers submit MHSUD claims for an advance determination of medical necessity. Predetermination services for MHSUD services are provided through the Member Assistance Program (MAP), which is managed by E4 Health. If you are using a CMR provider, a First Health provider, or a non-network provider for MHSUD services you should still contact E4 Health for a

predetermination, you cannot rely on a predetermination from CMR in connection with Mental Health and Substance Abuse Disorder services. See Sec. 6.6 on page 47 for a more detailed discussion of Predetermination.

The Welfare Fund encourages Participants and their families to call E4 Health to obtain an advanced determination that MHSUD treatment is medically necessary before claims are incurred which may not be paid by the Plan.

8.3 PSYCHOLOGICAL TESTING

(a) Definition: The assessment of an individual's emotional and behavioral status by administering and evaluating instruments developed to measure a variety of personal functions, such as personality characteristics, aptitudes, attitudes, psychological functioning or signs of psychological or neurological disorders. The purpose of the testing is to clarify diagnosis/diagnoses for the purpose of treatment planning for the treatment of a psychiatric disorder.

(b) Testing must be performed by a licensed doctoral psychologist with demonstrated competencies in psychological testing.

(c) Psychological Testing is subject to the Plan's benefit limitations for diagnostic services related to medical claims and will be limited to tests that are medically necessary.

(d) Exclusions: The following Psychological Testing tests are excluded as not medically necessary:

(1) Educational, vocational or occupational testing;

(2) Personnel or employment testing; and

(3) Testing performed for legal or forensic purposes.

8.4 EXCLUSIONS

(2) Psychiatric Residential Treatment

(1) Definition: Psychiatric Residential Treatment is a level of care that includes individualized and intensive treatment on a 24-hour basis in a residential setting. Treatment may be focused on psychiatric illness (behavior health) or substance abuse and alcoholism, or both, however, twenty-four hour skilled nursing services and daily supervision of a patient by a psychiatrist are not available.

(2) Psychiatric Residential Treatment is excluded both under the Plan's general "custodial care" exclusion, see Sec. 7.5(4) on page 61 and under this section because twenty-four hour skilled nursing services and the daily supervision by a psychiatrist are not available. This level of care is not appropriate for individuals at risk of harming themselves or others.

(3) Applied Behavioral Analysis

(1) Definition: Applied Behavioral Analysis (ABA) is a set of tailored interventions that can, through education and training, change an individual's behaviors in order to address problems functioning in social environments.

(2) All forms of Applied Behavioral Analysis are excluded both under the Plan's general "educational training" exclusion, Sec. 7.5(27) on page 63, and under this specific exclusion for "Applied Behavioral Analysis."

ARTICLE IX PRESCRIPTION DRUG COVERAGE

The Plan has an agreement with a Prescription Benefit Manager (PBM), LDI. When a member becomes eligible under the Plan, he will receive an ID card for himself and his Qualified Dependents. This card needs to be presented at the pharmacy when prescriptions are filled in order to receive any benefits. The member pays the applicable copayment for the drug category as shown below and the balance will be paid directly to the pharmacy by the Fund through LDI.

Prescription Drug benefits are based on whether a drug is a generic, the formulary preferred brand, or a non-preferred brand. The formulary changes as new drugs are released and drugs is available upon request. Coverage is also based on whether step-therapy protocols have been followed and whether the medication is a compound medication or a New to Market Drug.

Prescription drugs will only be covered in-network except as set out in Sec. 9.5 on page 70.

Specialty drugs are provided through the medical benefit see Sec. 7.3(22) on page 57.

9.1 DEDUCTIBLE

The Medical Calendar Year Deductible does not apply to prescription drug benefits and there is no separate Deductible for the prescription drug benefit. In other words, there is no deductible to be satisfied before obtaining prescription drugs at the applicable copayment and copayment amounts do not apply to any deductible. Prescription drug copayments do, however, apply to the Prescription Drug Calendar Year Out-of-Pocket Maximum. **Specialty Drugs are paid under your medical benefit not under your prescription drug benefit.**

9.2 MAXIMUM SUPPLY AND CO-PAYMENT

(a) Each new prescription or refill is limited to a maximum 30-day supply when obtained at a retail pharmacy. Up to a 90-day supply of certain drugs may be obtained through the Plan's Mail Order pharmacy.

(b) Co-payments for prescription drugs are set out in the schedules of benefits.

If the discounted price of the drug is less than the co-pay in the schedule of benefits, you pay only the discounted price.

(4) Each prescription obtained for the first time is limited to a maximum of a 30-day supply. Mail Order and retail LDI Pharmacies allow for a 31 to 90-day supply of maintenance prescriptions for 2½ times the 30-day co-pay. After the second fill of a maintenance medication you are required to use the mail order, the plan will not pay for additional fills at a retail pharmacy.

9.3 COVERED PRESCRIPTIONS

(1) Prescriptions for the treatment of acute and chronic illnesses and diseases;

(2) Birth Control pills (at least one of each type of contraceptive is covered at no cost to you, see Sec. 7.4(2) on page 59);

(3) Viagra, if medically necessary; limited to 6 pills per month; annual verification of Medical Necessity must be submitted to LDI; and

(4) Diabetic Supplies. The Plan has entered into arrangements with the Pharmacy Benefit Manager and/or other vendors to obtain Glucometers and diabetic testing supplies at a discount. These Glucometers and supplies are covered 100% by the Plan with no co-pay when obtained through the mail order pharmacy. No other Glucometers and diabetic testing supplies (including these preferred brands obtained from a retail pharmacy) are covered by the Plan except in the case of individuals using insulin infusion pumps. Glucometers and testing supplies needed by individuals using insulin infusion pumps may be covered under both the medical benefit and the prescription drug benefit and the benefit level may be different. Contact the Fund Office for assistance.

(5) Smoking cessation medications are covered as set out in the Preventive benefits Sec. 7.4(4) on page 60.

9.4 PRESCRIPTION DRUG EXCLUSIONS AND LIMITATIONS

(1) Medicines or drugs which do not require a prescription, except as covered under the Preventive and Wellness Benefit;

(2) Weight loss drugs except as covered as set out in Sec. 7.4(3)(b) on page 60;

(3) Drugs prescribed for treatment of conditions not covered under the Plan;

(4) Drugs prescribed for a use other than use for which the drug is approved; and

(5) Drugs prescribed for experimental and investigative purposes.

(6) New to Market (NTM) Drugs. When new prescription drug products are first available on the market, the Fund's Prescription Drug Manager reviews the safety and effectiveness of these new drug products. This process will follow the guidelines and process available through the Prescription Drug Manager's New-To-Market Clinical Evaluation Program. Not all new medications are required to go through this program. New to market drugs will automatically require a prior authorization for a minimum period of 6 months. During the review period, the NTM Drug will only be

covered by the Plan with approval available through the Prescription Drug Manager's prior authorization program.

9.5 OUT-OF-NETWORK

If a member is out of town and goes to a pharmacy that is not in the LDI network, the receipts for the prescriptions can be sent into the Fund Office. The member will be reimbursed for all but the applicable co-payments. Walgreens Pharmacy and CVS are Nationwide and part of the LDI network so should be used when away from home, if possible. This out of network benefit does not apply to a 90-day supply filled at a non-LDI pharmacy.

9.6 STEP THERAPY

It is often medically appropriate and cost effective for an individual to try an over-the-counter (OTC), generic or lower cost brand name medication before progressing to more expensive classes of medication. This is called Step-Therapy. Step Therapy medications are generally grouped into three "Steps":

- Step 1 Medications: These are usually OTC or generic medications which have been proven safe and effective to treat your condition. The cost to you and the Fund is the lowest when you use a Step 1 medication.
- Step 2 Medications: These are usually older, more well established, brand name drugs that are on the LDI preferred Drug Formulary. In general, these drugs are more expensive for you and the Fund than Step 1 medications but are less expensive then Step 3 medications.
- Step 3 Medications: These are usually newer more expensive brand name drugs that are not on the LDI formulary and are more expensive for you and for the Fund.

Where Step-Therapy is indicated, for example with medication for high blood pressure or high cholesterol, the Fund will only cover a prescription if the Member or Dependent follows the Step-Therapy program. If a medication that the Step-Therapy program indicates should be tried first has been tried within the last 120 days, or as otherwise indicated by medical protocol, and found to be ineffectual the person does not need to try that step again.

As of the printing of this SPD, Step Therapy protocols will be applied to all new prescriptions for the following medical conditions: proton pump inhibitors for stomach ulcers/acid reflux; medications for high cholesterol; angiotensin receptor blockers (ARBs) for high blood pressure; and medications and supplies for diabetics, whether filled at retail or through mail order. The medical conditions and classes of drugs subject to Step Therapy is subject to change so if you have a question regarding your medication call the Fund Office. A member or dependent taking a prescribed Step 2 or Step 3 medication prior to initiation of step-therapy for a specific medical condition or class of drugs will not be required to change to a medication on a "lower step."

However, "lower step" medications are often less expensive and individuals already on more expensive medications are encouraged to talk to their physicians about trying a less expensive "lower step" medication.

9.7 SPECIALTY DRUGS

Specialty Drugs are covered under the medical coverage benefits of the Plan not the prescription drug benefits, see Sec. 7.3(22) on page 57.

9.8 COMPOUND PRESCRIPTION MEDICATIONS

A. The first fill, up to a 30-day supply, of a prescription for a Compounded Medication can be filled by any pharmacy in the LDI network;

B. All subsequent supplies will only be covered when the prescription is filled at a pharmacy in the LDI closed compounding network. Currently the closed compounding network consists of Petranek's Pharmacy in Libertyville, IL. Information about the network can be obtained from LDI.

C. The co-pay for a pharmacy in the closed compounding network and for the first 30-day supply at any LDI pharmacy is the same as the co-pay for any other prescription.

9.9 RETIREE COVERAGE

Prescription coverage is available to pre-Medicare retiree members who retire and sign up for the coverage at the time of retirement as set out in Article XII beginning on page 80.

For Medicare Retirees enrolled in the Humana Medicare Advantage Plan sponsored by the International, Medicare prescription drug coverage is provided as part of that plan. Information about other Medicare plans that offer prescription drug coverage is available at www.medicare.gov; from your State Health Insurance Assistance Program; or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

ARTICLE X HEARING AIDS AND VISION BENEFITS

10.1 HEARING AID COVERAGE

The Plan will provide coverage for hearing aids for all Members and Qualified Dependents. The Plan pays the first $1,000/ear for medically necessary hearing aids prescribed by a Physician specializing in ear, nose, and throat (an ENT). Non-Medicare Retirees who enroll in the Plan's retiree coverage can purchase this coverage as part of the hearing aid/vision benefit. Medicare Retirees can purchase the hearing aid/vision coverage separately.

10.2 VISION BENEFITS

(a) Benefits will be payable for a covered person for covered charges incurred once in a calendar year as set out in the schedules of benefits.

(b) LASIK:

The Plan covers LASIK procedures, subject to the following restrictions:

Coverage is limited to one procedure per eye per covered person's lifetime.

After a $200 deductible, benefits are payable at the applicable rates depending on the network participation of the provider. The maximum benefit per eye is $1,000, including Physician's bill, surgery center and anesthesia.

No eyeglass or contact lens benefits will be payable for that covered person for a period of ten (10) years from the date of the original Lasik procedure.

(c) LIMITATIONS AND EXCLUSIONS ON VISION BENEFITS. Benefits are limited for each covered person to payment for one exam, one pair of lenses, and one pair of frames (or one set of contact lenses in place of frames and lenses) in any calendar year.

The following services and materials are excluded from coverage:

(1) Lenses that can be obtained without a prescription;

(2) Orthoptic, vision training, or subnormal vision aids;

(3) Refractions; and

(4) Services or supplies not listed in the above schedule.

(d) SPECIAL VISION CARE RULES

(1) These benefits do not apply to any of the Out-of-Pocket Maximums in the Plan;

(2) The benefits are assignable and will be paid to the provider, unless the covered person submits proof of payment to the Fund Office.

(3) There is not a deductible amount (except for Lasik) or co-insurance, although the member will be responsible for a copayment for eye exams and for all amounts above the coverage limit.

(e) Vision benefits provided through the Welfare Plan are separate from the Plan's medical benefits. You will have the opportunity to opt out of the Welfare Plan's vision care benefit upon commencement of your coverage and prior to the beginning of each plan year. Any election to opt out of vision care benefits must be submitted to the Welfare Fund Office in writing. There is NO monthly or annual premium for vision care benefits with the Welfare Plan and you will not receive any money or thing of value for opting out of such coverage.

ARTICLE XI DENTAL BENEFITS

11.1 GENERAL PURPOSE

The Plan provides benefits to the extent explained below for the services and supplies listed under Preventive, General, Major and Orthodontia. The Benefit Period is the calendar year. There is a dental Deductible of $75 per individual, maximum of three Deductibles per family ($225), which is only applied to Basic General Services and Major Services.

11.2 BENEFIT MAXIMUMS

The Plan will pay dental benefits per person each calendar year up to the maximum set out in the applicable Schedule of Benefits.

Orthodontia benefits do not apply to the dental Calendar Year maximum. There is a separate lifetime maximum for each person for orthodontia benefits.

11.3 COVERED SERVICES AND SUPPLIES

The following services and supplies are covered up to the maximum benefit. The percentages paid are stated below.

(a) For Preventative Services the Deductible is waived and benefits are paid at 100%. Preventative services are:

(1) routine periodic examinations, four times per year;

(2) bite-wing x-rays twice in one year;

(3) diagnostic x-rays as required;

(4) full-mouth x-rays, once in any 36 consecutive months;

(5) dental prophylaxis (cleaning, scaling and polishing), four times per year;

(6) topical fluoride application for Qualified Dependents under age 19, twice in any benefit period;

(7) emergency relief treatment (minor procedure to temporarily reduce or eliminate pain) as needed; and

(8) space maintainers that replace prematurely lost teeth of Qualified Dependent children under age 16 (once in five years).

(b) For Basic General Services, the deductible is applied to the following services, and thereafter benefits are paid as set out in the applicable schedule of benefits:

(1) restorative services using amalgam, synthetic porcelain and plastic filling material; periodontics (treatment for diseases of the gums and bone supporting the teeth, including periodontal splinting);

(2) endodontics (root canal filling and pulpal therapy);

(3) oral surgery, including simple and surgical extraction;

(4) consultations and laboratory examinations;

(5) injections of antibiotic drugs;

(6) repair and/or recementing of inlays, onlays, crowns, bridges and dentures;

(7) rebasing of dentures; and

(8) local anesthesia related to basic services.

(c) For Major Services, benefits are paid at as set out in the applicable schedule of benefits:

(1) prosthesis (bridges and dentures);

(2) crowns, jackets, inlays and onlays when teeth cannot be restored with a filling material; and

(3) local anesthesia related to major services.

(d) Orthodontia Benefits:

(1) The deductible is as set out in the applicable schedule of benefits.

There is no maximum for orthodontic treatment provided to a Dependent up to age 19.

(2) For orthodontic treatment the Plan will only cover charges from dentists in the plan's dental network.

(3) Covered Orthodontic Services and Supplies:

(a) orthodontic diagnostic procedures and treatment, including related oral examinations;

(b) surgical therapy;

(c) appliance therapy; and

(d) functional/myofunctional therapy.

(4) Timing of Orthodontic Care Benefits. Orthodontic care benefits will be paid on the following basis: The initial charge will be paid following initial installation. Thereafter, payment will made in equal installments on the balance quarterly, up to the Plan maximum, for the estimated duration of the treatment plan, as long as the patient remains covered under the Plan.

11.4 DENTAL COVERAGE LIMITATIONS AND EXCLUSIONS

Benefits are not provided for the following:

(a) Services or supplies partially or wholly cosmetic in nature;

(b) Facings on pontics or crowns behind the second bicuspid. The cost to improve the cosmetic appearance of rear teeth is not covered;

(c) Services or supplies furnished or reimbursed by any government or government program or law, unless payment is legally required;

(d) Services or supplies due to occupational injuries or diseases, to the extent covered by Workers' Compensation; or similar legislation;

(e) Specialized or personalized services;

(f) Services or supplies not furnished by a dentist except x-rays ordered by a dentist and services of a licensed dental hygienist under the dentist's supervision;

(g) Training in, or supplies used for, dietary counseling, oral hygiene or plaque control;

(h) Treatment of Temporomandibular Joint dysfunction (TMJ). TMJ is covered under medical;

(i) Services or supplies due to war or acts of war, declared or undeclared;

(j) Services that you would not be required to pay for if there was not insurance;

(k) Charges for removing stitches and post-operative examinations that have been included in the initial charge for a procedure listed in the Covered Dental Expenses section;

(l) Charges for adjusting dentures or bridges within six months of installation;

(m) Failure to keep a scheduled visit with the dentist;

(n) Services or supplies which do not meet accepted standards of dental practice, including those which are Experimental or Investigative in nature;

(o) Completion of insurance forms;

(p) Replacement of bridges or dentures which cannot be satisfactorily repaired will be covered only once in five years;

(q) Expenses that are incurred while you are not covered under this plan, unless a plan provision specifically provides otherwise. For this purpose, an expense is incurred at the time the service or supply is actually provided; and

(r) Charges for dental services provided by a Close Relative (see Sec. 2.5 on page 15) for definition of close relative.

11.5 HOW TO OBTAIN YOUR DENTAL BENEFITS

(a) The Plan has entered into an arrangement with Delta Dental of Missouri (DDMO) for access to the DDMO network of dental providers. Your out-of-pocket costs may vary depending on your choice of provider. You have three options:

1. PPO Participating Dentist (Delta Dental PPO Network). Delta Dental's PPO network consists of dentists who have agreed to accept payment based on the lesser of usual fees or the applicable PPO Maximum Plan Allowance and to abide by Delta Dental policies. This network offers you cost control and claim filing benefits.

2. Non-PPO Participating Dentist (Delta Dental Premier Network). Delta Dental's Premier network consists of dentists who have agreed to accept payment based on the lesser of filed fees or the applicable Premier Maximum Plan Allowance. This network also offers you cost control and claim filing benefits. However, your out-of-pocket expenses may be higher with a Premier dentist because you may be paying a percentage of a higher amount.

3. Non-Participating Dentist. If you go to a non-participating dentist (not contracted with a Delta Dental plan), DDMO will make payment directly to you based on the lesser of the dentist's billed charge or the applicable Maximum Plan Allowance.

(b) You are not responsible for paying a participating dentist any amount that exceeds the PPO or Premier Maximum Plan Allowance, whichever is applicable. You are only responsible for non-covered charges, deductible, and co-insurance amounts. In addition to saving you money, participating dentists (PPO and Premier) have the necessary forms needed to submit your claim directly to Delta Dental and to be paid directly. All you have to pay is your share of the charge. You can find a list of PPO and Premier participating dentists in your area at *deltadentalmo.com*.

(c) If you use a Non-Participating Dentist it will be your obligation to make full payment to the dentist. The dentist may or may not file the claim for you; however, ultimately it is your obligation to make sure the claim is filed. Obtain a claim form from the Fund Office or from DDMO.

(d) To verify coverage or for information about the Plan's dental benefits, the dentist's office may call Delta Dental at (314) 656-3001.

(e) If the proposed dental treatment plan will cost over $200, you or your dentist may contact DDMO to predetermine the necessity of services and the allowable amount. This will enable you to estimate in advance, the amount that will be paid by the Plan and the amount for which you may be responsible. When the post-service claim is received, benefits will be determined without giving deference to the predetermination.

For information about how to file a dental claim or appeal a claims decision, please refer to Article XV Claim and Appeal Procedures.

11.6 COORDINATION OF BENEFITS

Your dental benefits have a Coordination of Benefits provision, which means that if you or your Qualified Dependents are eligible to receive benefits under more than one group dental benefits program, the benefits will be coordinated so that the two programs together will not pay more than 100% of covered expenses. The COB provision does not apply to any personal, non-group insurance policies. See Article XIII beginning on page 86 for details.

11.7 DENTAL BENEFITS ARE A SEPARATE BENEFIT

Dental benefits provided through the Welfare Plan are separate from the Plan's medical benefits. You will have the opportunity to opt out of the Welfare Plan's dental care

benefit upon commencement of your coverage and prior to the beginning of each plan year. Any election to opt out of dental care benefits must be submitted to the Welfare Fund Office in writing. There is NO monthly or annual premium for dental care benefits with the Welfare Plan and you will not receive any money or thing of value for opting out of such coverage.

ARTICLE XII RETIRED MEMBER BENEFITS

12.1 ELIGIBILITY FOR COVERAGE

Available To pre-Medicare Retirees, pre-Medicare covered Dependents of Retirees, and pre-Medicare Pre-Retirement Surviving Dependents. **Medical and Prescription Drug benefit are not available through the Welfare Plan to anyone eligible for Medicare.** Ancillary coverages available to Medicare Retirees are described in Sec. 12.3 on page 84.

Enrollment by a Retiree or Dependent or Pre-retirement Surviving Dependent is in lieu of COBRA and by enrolling in this coverage COBRA coverage is declined.

(1) Any Class I or II Member who meets each of the following requirements may self-pay for medical, prescription drug and dental benefits at the appropriate monthly rate until such time as the Member informs the Plan that the Member no longer requires coverage or the Member becomes eligible for Medicare.

(a) The Member is receiving a retirement or disability pension from the International Association of Sheet Metal, Air, Rail and Transportation Workers ("SMART") Local Union No. 36 Pension Fund;

(b) The Member is not yet eligible for Medicare (coverage ends on Medicare eligibility regardless of whether the individual actually enrolls in Medicare);

(c) Immediately prior to retirement or disability, the Member had active coverage in this Welfare Fund for at least 5 consecutive years (60 months) without a break in coverage or meets the requirements of paragraph (8) of this Sec. 12.1;

(d) The Member has at least 120 months of active coverage prior to retirement or disability; and

(e) If the Member experienced a break in coverage in the twenty (20) years prior to retirement or disability, the Member had active coverage after the break in coverage at least equal to the length of the break in coverage (if there were multiple breaks in coverage then the combined active coverage after the first break in coverage must equal or exceed the total combined breaks in coverage).

(2) Qualified Dependents of Retirees.

(a) The Qualified Spouse of a Retiree is defined as a person married to the Retiree and covered by the plan on the day active coverage terminated and retiree coverage began.

(b) The Qualified Dependent of a Retiree is defined as a person who was a Dependent of the Retiree and covered by the plan on the day active coverage

terminated and retiree coverage began or a child born or placed for adoption with the Retiree after retirement.

(c) A Retiree cannot decline coverage for himself and elect coverage only for his Dependents. This does not apply in the case of a Surviving Spouse.

(3) A pre-retirement surviving Dependent is defined as a Member's Dependent who was a Dependent at the time of the Member's pre-retirement death. The pre-retirement surviving Dependent of any Class I or II Member who meets each of the following requirements may self-pay for medical, prescription drug and dental benefits at the appropriate monthly rate:

(a) At the time of death, the Member would have been eligible to retire early under the International Association of Sheet Metal, Air, Rail and Transportation Workers ("SMART") Local Union No. 36 Pension Fund because the Member had earned 15 Years of Pension Plan Credited Service and had attained age 55 before death;

(b) The Surviving Spouse is receiving a pre-retirement surviving spouse annuity from the SMART Local Union No. 36 Pension Fund;

(c) Immediately prior to the Member's death, the Member had active coverage in this Welfare Fund for at least 5 consecutive years (60 months) without a break in coverage or met the requirements of paragraph (8) of this Sec. 12.1;

(d) The Member had at least 120 months of active coverage under this Welfare Fund prior to death; and

(e) If the Member experienced a break in coverage in the twenty (20) years prior to death, the Member had active coverage after the break in coverage at least equal to the length of the break in coverage (if there were multiple breaks in coverage then the combined active coverage after the first in break in coverage must equal or exceed the total combined breaks in coverage).

(4) The duration of coverage for the Dependent spouses and children of Retirees and deceased Members is based on the reason for coverage and the age of the Member when coverage began:

	spouse	dependent child
dependent of normal or early Retiree	until Medicare eligibility	18 months
dependent of disabled Retiree who met all the requirements for retiree coverage except the age requirement AND was within 10 years of the age requirement (ie, was age 45 or older)	until Medicare eligibility	36 months
dependent of disabled Retiree who failed one of the requirements for retiree coverage or met the other requirements BUT was not within 10 years of the age requirement (ie was not yet age 45)	36 months	36 months
surviving dependent of deceased participant who was within 10 years of the age requirement for retirement (ie, was age 45 or older)	until Medicare eligibility	36 months
surviving dependent of deceased participant who was NOT within 10 years of the age requirement for retirement (ie was not yet age 45)	36 months	36 months

Coverage ends when the surviving spouse or Dependent

(a) informs the Plan that she or he no longer requires coverage;

(b) becomes covered by another group health plan;

(c) becomes eligible for coverage in a group health plan as an employee (or retiree) or the dependent of an employee (or retiree) regardless of whether the surviving spouse or dependent enrolls in such cover,

(d) becomes eligible for Medicare;

(e) fails to timely pay any required premium (for example if the retirement benefit is less than the premium); or

(f) the Surviving Spouse is no longer eligible to receive a pension from the Pension Fund.

(5) In determining whether a Member has met the requirements for Retiree Self-Payment,

(a) any period of disability continued coverage in Sec. 3.7 on page 28 and any period of self-payment under Sec. 3.10 on page 29 counts as active coverage for

satisfying the rules in (1)(c) and (d) and (3) (c) and (d) of this section 12.1, and is not considered a break in coverage;

(b) Coverage continued through COBRA will not satisfy the rules in (1)(c) and (d) and (3) (c) and (d) but does not count as a break in coverage for 1(e) and 3(e) of this section 12.1; and

(c) Coverage suspended or terminated because of military service under USERRA will not count as a break in coverage and will be disregarded in determining whether the Member has satisfied the requirements for retiree coverage.

(6) An eligible retired Member or Pre-retirement Surviving Spouse may elect to continue coverage under this provision or under COBRA as described in Sec. 3.14, beginning on page 33. If self-payment is elected under this provision, then COBRA is declined and such coverage will be provided in lieu of COBRA Continuation Coverage.

(7) If the Member was married at the time he started to receive his retirement and elected, with spousal consent, a form of benefit other than a joint and survivor annuity, then the Surviving Spouse may submit direct payments to the Fund Office for coverage as long as the spouse was covered by the Retiree coverage at the time of the Retiree's death.

The Fund Office may, but is not required to, send the Surviving Spouse a reminder that payments are due. A failure to timely make self-payments will result in the termination of coverage.

(8) An Active (Class I) Member with 25 or more years of coverage in the Plan as a Class I Member who ceases to perform work covered under a Collective Bargaining Agreement requiring contributions to this Plan but continues to work without a break in employment for the same contributing Employer in a managerial capacity, for example as an estimator or salesperson and continues coverage in the plan as an Office Employee (Class IV) Member can satisfy the 60 month requirement for retiree coverage in rules in (1)(c) and (3)(c), of this section 12.1, by participation as an Office Employee (Class IV) Member.

12.2 PREMIUM

(1) The monthly premiums for this coverage will be deducted from the Retiree's monthly pension benefit. Forms must be completed at the time the Member applies for Pension Benefit. If the monthly pension benefit is insufficient to cover the premium for coverage then the Retiree may directly pay the difference in premium to the Fund Office.

(2) The premiums due from Class VII Members and Pre-Retirement Surviving Spouses shall be set by the Trustees on a regular basis. Pre-Retirement Surviving Spouses are only eligible to participate in Premium Groups A and B. The premium rate due from a Class VII Member shall be based, in part, on the Member's years of pension credits in the International Association of Sheet Metal, Air, Rail and Transportation Workers ("SMART") Local Union No. 36 Pension Fund or the National Pension Fund (for years when the Employer did not contribute to the SMART Local Union No. 36 Pension Fund) as set out below:

Premium Group A:	(1) Class VII Members who retire after July 1, 2008 with more than 25 years of pension credit, and (2) all Class VII Members who retired prior to July 1, 2008
Premium Group B:	Class VII Members who retire after July 1, 2008 with 15 or more, but less than 25, years of pension credits
Premium Group C:	Class VII Members who retire after July 1, 2008 with less than 15 years of pension credits
	Retired Members eligible for Medicare are only eligible to enroll through the Plan in the dental benefit or the vision and hearing aid benefit or both

It is the intent of the Trustees to set the premiums so that the premium paid by a Member in Group A, B, or C decreases with the number of years of pension credit required so that the lowest premium is paid by Members in Group A and the highest premium is paid by Members in Group C. As with all other aspects of the plan of benefits, the Trustees retain discretion to change the premium or the method for setting the premium for retiree coverage, and to change or eliminate benefits or the plan of benefits.

12.3 COVERAGES – NON-MEDICARE RETIREES (CLASS VII)

(1) A retired Member not eligible for Medicare can elect to continue to receive benefits in Non-Medicare Retiree Plan A or Non-Medicare Retiree Plan B. The benefits in Non-Medicare Retiree Plan A are the same as for active members. Non-Medicare Retiree Plan B is a reduced plan of benefits for a lower premium. A retiree may elect Plan A or Plan B only one time when benefits begin.

(2) A retiree in Plan A or Plan B may choose one of the following benefit options:

* only medical, and prescription drug benefits;
* medical, prescription drug, and vision benefits (the cost is the same as without vision benefits);
* medical, prescription drug, vision and dental benefits.

A retiree may drop dental and vision benefits but, once they are declined, he or she cannot add these benefits at a later time.

12.4 COVERAGES – MEDICARE RETIREES

Effective January 1, 2015, the Plan stopped providing medical and prescription drug coverage to Retirees eligible for Medicare. These Retirees are eligible to enroll, through the International Association of Sheet Metal, Air, Rail and Transportation Workers, in a Medicare Advantage Plan (currently provided through Humana). Premiums for this plan can be paid by deductions from retirement plan benefits.

(1) Medicare prescription drug coverage is part of the insured Medicare plan and not provided separately by the Welfare Plan.

(2) The benefit terms of the insured plan as well as the rules for filing claims and appeals are set out in a separate document from the insurer and that document controls over anything to the contrary in this SPD.

(3) A Medicare Retiree enrolled in the insured Medicare plan will be able to enroll in the hearing aid and vision benefits from the Plan, see Sec. 12.5 and Sec. 12.6, below, and in the retiree dental plan.

12.5 HEARING AID BENEFITS

Class VII and enrolled Medicare Retiree Members

For Members and Qualified Dependents, the plan pays the first $1,000/ear for medically necessary hearing aids prescribed by a physician specializing in ear, nose, and throat (an ENT).

12.6 VISION BENEFITS

Non-Medicare Retirees (Class VII) and Medicare Retiree Members who elect and pay the premium for this benefit have the same vision benefits as active Members as set out in Article X beginning on page 72.

Medicare Retirees should submit bills for examination charges to their Medicare Plan because this charge may also be covered by the Medicare Plan.

12.7 DENTAL BENEFITS

Non-Medicare Retirees (Class VII) and Medicare Retiree Members who elect and pay the premium for the Dental Benefit have the same benefits as active Members as set out in Article XI beginning on page 74.

ARTICLE XIII COORDINATION OF BENEFITS

13.1 GENERAL PURPOSE

All of the benefits provided by this Plan are subject to the provisions of this Article. This Plan has been designed to help you meet the cost of sickness or injury. It is not intended that you receive greater benefits than the actual medical or dental expense incurred. Therefore, the amount of benefits payable under this Plan will take into account any coverage you have under other plans or programs; and the benefits under this Plan will be coordinated with the benefits of other plans or programs, as set forth in this Article.

13.2 APPLICABILITY

(a) This Coordination of Benefits ("COB") provision applies to This Plan when a Member or the Member's covered Qualified Dependent has health care coverage under more than one Plan. The terms "Plan" and "This Plan" as used in this Article are defined below.

(b) If this COB provision applies, the order of benefit determination rules in this Plan should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan.

The benefits of This Plan:

(1) Shall not be reduced when, under the order of benefit determination rules, This Plan determines benefits before another Plan; but

(2) May be reduced when, under the order of benefits determination rules, another Plan determines its benefits first. The above reduction is described in "Effect on the Benefits of This Plan" later in this Article.

13.3 DEFINITIONS SPECIFIC TO COORDINATION OF BENEFITS

(a) "Plan" is any of these which provides benefits or services for, or because of, medical, prescription or dental care or treatment:

(1) Group insurance or group-type coverage, whether insured or self-funded. This includes prepayment, group practice or individual practice coverage. It also includes coverages such as school accident-type coverage, medical payments coverage under group or individual automobile, homeowner's, or general liability insurance and group or individual no fault automobile insurance. The Fund, however, does not coordinate with the medical payment coverage of a homeowner's policy for a policy covering the house in which the injured person

resides and does not coordinate with the medical payment coverage of other homeowner's policies if the claim is $2,000 or less.

(2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

Each contract or other arrangement for coverage under (1) or (2) is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one, each of the parts is a separate Plan.

(b) "This Plan" is the International Association of Sheet Metal, Air, Rail and Transportation Workers ("SMART") Local Union No. 36 Welfare Fund.

(c) "Primary Plan/Secondary Plan" is the order in which the Plans provide coverage. The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person. When This Plan is a Primary Plan, its benefits are determined before those of the other Plan without considering the other Plan's benefits. When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and a Secondary Plan as to a different Plan or Plans.

(d) "Allowable Expense" means a necessary, reasonable and customary item of expense for health care; when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made. However, if an expense is one that would not be covered by This Plan in absence of other coverage it will not be an Allowable Expense under this provision. See the exclusions and limitations set out in the Schedules of Benefits, in Sec. 7.5 beginning on page 61, and throughout this document.

When benefits are reduced under a Primary Plan because a covered person does not comply with the provision of that Plan, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to timely filing requirements, precertification of admissions, or services, and preferred provider arrangements.

(e) "Claim Determination Period" means a calendar year. However, it does not include any part of year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

(f) If a provider, such as a pharmacy, is unable to submit a claim to the Plan as a secondary claim after payment by the Primary Plan then the Fund will reimburse you the amounts covered by the Plan if you submit evidence showing what was paid by the primary carrier and what you paid.

13.4 ORDER OF BENEFIT DETERMINATION RULES

(a) General. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless;

(1) The other plan has rules coordinating benefits with those of This Plan; and

(3) Both those rules and This Plan's rules, in Subsection (b) below, require that This Plan's benefits be determined before those of the other plan.

(b) Rules. This Plan determines its order of benefits using the first of the following rules which applies:

(1) Non-Dependent/Dependent. The benefits of the plan which covers the person as an employee, member, or subscriber including as a retiree (that is, other than as a dependent) are determined before those of the plan, which covers the person as a dependent.

(2) The benefits of the plan which covers the person as a spouse are determined before those of the plan which cover the person as a child.

(4) Dependent Child/Parents not Separated or Divorced. Except as stated in Paragraph B(3) below, when this Plan and another Plan cover the same child as a dependent of different persons, called "parents:"

(i) The benefits of the Plan of the parent whose birthday falls earlier in the calendar year are determined before those of the Plan of the parent whose birthday falls later in that year, the year of birth of the parents is not considered for this purpose; but

(ii) If both parents have the same birthday, the benefits of the Plan that covered one parent longer are determined before those of the Plan that covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in (i) immediately above, but instead has a different rule benefits will be pro-rated based on the schedule of benefits of the two plans.

(5) Dependent Child/Parents Separated or Divorced. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(i) First, the plan of the natural parent with custody of the child;

(ii) Second, the plan of the step-parent with the custody of the child;

(iii) Third, the plan of the natural parent not having custody of the child; and

(iv) Finally, the plan of the step-parent not having custody of the child.

However, if the specific terms of a court decree or child support order state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other natural parent shall be the Secondary Plan. This paragraph does not apply with respect to any claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(6) Joint Custody. If the specific terms of a court decree state that the natural parents shall share joint custody, without stating that one of the natural parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules for non-divorced parents outlined in Paragraph (b)(3), above. This rule also applied In the case of an adult-dependent child, where neither natural parent has custody.

(7) Active/Inactive Employee. The benefits of a plan which covers a person as an employee, who is neither laid off nor retired, are determined before those of a plan which covered that person as a laid off or retired employee. The same would hold true if a person is a dependent of a person covered as a retiree and an employee, unless one of the rules stated above requires a different result, for example (1) provides that coverage based on the individual's employment comes before coverage based on dependent status and (2) and (3) control the coverage rules for dependent children. If the other plan does not have this rule, and if as a result, the plans do not agree on the order of benefits, this Rule (5) is ignored.

(8) Continuation coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:

(i) First, the benefits of a plan covering the person as an employee, member or subscriber. The same would hold true if a person is a dependent of a person, unless one of the rules stated above requires a different result; and

(ii) Second, the benefits under the continuation coverage.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule (6) is ignored.

(9) Longer/Shorter Length of Coverage. If none of the above rules determine the order of benefits, the benefits of the plan, which covered an employee, member or subscriber longer, are determined before those of the Plan, which covered that person for the shorter term.

(10) Notwithstanding anything to the contrary contained herein, to the extent permitted by law, this Plan shall be secondary to Medicare with respect to Members and Qualified Dependents who are eligible for Medicare.

If the rules of this Plan and the rules of the other plan are in conflict so that each plan's rules would make it secondary, then this Plan will pay up to 50% of the claim either as the primary or the secondary plan if the other plan will also pay 50% of the claim.

13.5 EFFECT ON THE BENEFITS OF THIS PLAN

a) This Section applies when, in accordance with the "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other plans. In that event the benefits of This Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in subsection (b) below.

b) The benefits of This Plan will be reduced when the sum of:

(1) The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and

(2) The benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion and is then charged against any applicable benefit limit of This Plan.

13.6 RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Various information, including Personal Health Information (PHI), such as information about the claim, other insurance and the relationship of the insured to the claimant, is needed to pay claims under these COB rules. To assist the Fund in paying these claims, the Fund may get needed PHI from or give it to any other organization or person. The Fund, its Administrators and the Trustees need not tell, or get authorization from, any person to do this. Each person claiming benefits under This Plan must give the Fund any information it needs to evaluate and pay the claim.

13.7 FACILITY OF PAYMENT

A payment made under another plan may include an amount, which should have been paid under This Plan. If it does, the Fund may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Fund will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

13.8 RIGHT OF RECOVERY

If the amount of the payments made by the Fund is more than it should have paid under this COB provision, it may recover the excess from one or more of:

(a) The persons it has paid or for whom it has paid;

(b) Insurance companies; or

(c) Other organizations.

The "amount of the payment made" includes the reasonable cash value of any benefits provided in the form of services.

Questions regarding whose coverage should be primary for Qualified Dependents should be referred to the Fund Office. It may be necessary for the Member to supply the office with information (e.g. divorce decrees, separation papers, court orders, rules of COB from the other plan, etc.) to determine primary coverage for Qualified Dependents. Claims will not be processed until the necessary information is submitted to the Fund Office.

13.9 COORDINATION WITH A WRAP PLAN

This Plan will apply coordination when the primary plan is designed so that it pays a minimal amount and then, if there is other coverage, only pays amounts not paid by a secondary or tertiary plan. This type of plan is sometimes referred to as a "wrap plan with a no-loss provision." In situations where this Plan is secondary and the primary plan pays less when there is secondary coverage than when it is the only coverage this Plan will only pay the amount the participant's or Dependent's other plan would not have paid had it been the only plan providing coverage. Example: The other plan pays the first $1,000 at 100% and then pays the remainder at 80% except that if there is secondary coverage the other plan only pays the amounts above $1,000 that are not covered by a secondary plan. In this situation, this plan will only pay up to 20% of the amount above $1,000. This rule takes precedence over any Coordination of Benefit rule to the contrary in this Plan or the other plan.

ARTICLE XIV RECOVERY FROM INSURANCE COMPANY OR THIRD PARTIES

14.1 THIRD PARTY DEFINED

Reference in this Article to a "third party" includes any insurance company or other party, including a worker's compensation carrier, which may be obligated to make a payment to or for the benefit of a Member or Qualified Dependent.

14.2 SUBROGATION RIGHTS OF THIS FUND

If a Member is entitled to weekly disability income benefits or if a Member or Qualified Dependent is entitled to medical benefits under this Plan by reason of illness or injury resulting from the negligent or wrongful conduct of another (third) party or from a work related incident, this Fund shall be fully subrogated to any and all rights of recovery and causes of action which the Member or Qualified Dependent may have against any liable third party to the following extent:

(a) Disability Income Benefits. The right of this Plan to recover for weekly disability income benefits paid shall be the amount of benefits paid by this Plan.

(b) Medical Benefits. The right to recovery by this Fund for medical benefits shall be the lesser of: (i) the amount of such benefits actually paid; or (ii) the amount by which such benefit paid taken together with the amount recovered by the Employee or his Qualified Dependent to the same medical expenses would exceed 100% of such medical expenses. In determining whether the amounts paid by the Fund and the amounts recovered by the Employee or Qualified Dependent exceed the medical expenses all amounts recovered by the Employee or Qualified Dependent will be deemed to be for medical expenses, except to the extent specifically and verifiably for property damage, regardless of how classified.

14.3 RIGHT OF REIMBURSEMENT

The Plan specifically rejects the "make whole" doctrine and the Plan is granted a specific and first right of reimbursement out of the proceeds of any settlement, judgment or other payment by a third-party liable to the Member of Qualified Dependent. This right of reimbursement comes first even if the member is not paid for all of his claims for damages or if the payment he recovers is for damages other than medical expenses. If the injured individual is a Dependent both the Member and the Dependent are obligated to make sure the Plan is reimbursed and to make sure that any attorney or agent assisting in recovery acknowledges the Plan's right to reimbursement.

14.4 EXAMPLE OF SUBROGATION

An eligible Employee is injured in an automobile accident for which he has a claim against the other driver (or that driver's insurance company or the Employee's own insurance company under uninsured motorist coverage). The Employee has $11,000 of medical expenses of which $10,000 would be paid by this Plan and $5,000 of lost wages of which $2,000 would be paid as weekly income disability benefits from this Plan, the Employee recovers more than $16,000 on his claim against the other driver, all of which is classified as "pain and suffering." The Employee's recovery exceeds the full $11,000 in medical expense and the full $5,000 of lost wages; this Fund is entitled to recovery of the full $10,000 payable for medical expenses and of the full $2,000 payable for weekly income disability benefits; that would be the amount of this Fund's subrogation rights. If recoverable by the Employee, this amount must be repaid to the Fund.

14.5 OBLIGATION TO PURSUE OTHER SOURCES OF BENEFIT AND TO REPAY THE FUND

Any Employee or Qualified Dependent who is or may be entitled to benefits or payments from any other source is obligated to immediately report that fact in writing to the Fund. Other sources include, but are not limited to, another plan, a third party, or an Employer or insurer under Worker's Compensation. The Employee and Qualified Dependent each has an obligation to diligently pursue recovery of benefits from such other source. If the Employee or Qualified Dependent fails to do so, this Fund shall have no obligation to provide benefits for the occurrence in question and, to the extent that this Fund may have already provided benefits, the Employee and Qualified Dependent shall be obligated to return such benefits to this Fund. The Fund's right to recovery is an equitable right. The Fund does not cover as a benefit, claims for services for which a third party is responsible, therefore, this right of recovery and subrogation is merely the equitable correction of the payment and not a monetary claim for damages. Any person receiving money that belongs to the Fund does so as a constructive trustee for the Fund.

In any situation when this Fund may have made payments for which it was not obligated, the Employee and his Qualified Dependent shall reimburse this Fund. The Fund has the right to withhold future benefits until there is full reimbursement of amounts that were paid in error.

14.6 ESTABLISHMENT OF LIEN

Any monies a covered person, his or her agent, or attorney recovers from a third party must be held in an equitable or constructive trust by the person, his or her agent, or attorney, until the money is apportioned between the Eligible Individual and the Plan.

By accepting benefits from the Plan, the participant and beneficiary specifically acknowledge and agree that, as set out in the Supreme Court's opinions in *Sereboff v. Mid Atlantic Medical Services, U.S. Airways, Inc. v. McCutchen,* and subsequent cases,

the Fund is granted an Equitable Lien by Agreement in the proceeds of any payment, settlement, judgment or other recoveries from any third party (including any tort feasor or insurer) up to the amounts paid by the Fund regardless of whether money received from the third party is maintained in a separate account or co-mingled with other assets of the injured party, his agent or attorney, or any other person. This is a first right of reimbursement and once payment is made to or on behalf of the Member or Qualified Dependent the Fund is granted a lien that can be satisfied from any identifiable funds in the possession or control of the Member or Qualified Dependent or the agent, attorney, or representative thereof.

14.7 OBLIGATION TO PROTECT RIGHTS OF FUND AGAINST THIRD PARTY

Any covered person receiving benefits from this Fund for any occurrence shall hold in trust for this Fund all rights of recovery against any third party and shall take no steps, which will impair those rights of recovery. The failure to comply with the requirements for payment by the third party, such as the rules of a worker's compensation law or carrier, is an impairment on the right of recovery. This Fund is not obligated to pay claims where the covered person has impaired the right of recovery and may recover from the covered individual amounts paid under those circumstances.

The Member and his Qualified Dependent shall be obligated to pursue those rights on behalf of the Fund. In addition, if the Trustees of the Fund so decide, the Fund itself may pursue any such rights or recovery in the name of the Member or of his Qualified Dependent, or both, or in the name of the Fund, and the Member and Qualified Dependent shall be obligated to fully cooperate with the Fund in any endeavor by the Fund to recover benefits paid.

Based upon the circumstances, the Trustees may, in their sole discretion, agree to pay a portion of the attorney fees incurred by the individual in pursuit of recovery from the third party. In those situations where the Fund agrees to pay a portion of the attorney fees the Fund will not generally agree to pay attorney fees in excess of 33 1/3% of the recovery.

ARTICLE XV TRUSTEE AUTHORITY, AMENDMENTS

15.1 TRUSTEES DISCRETIONARY AUTHORITY

Notwithstanding any other provisions of this Summary Plan Description or any other document governing this Plan, expressed or implied, to the contrary, the Trustees shall have full power to interpret and administer this Plan in any way that they deem appropriate to achieve its purposes, based on their discretion. The Trustees shall also have discretionary authority to determine eligibility for benefits. They are authorized to establish rules and guidelines, to resolve conflicts in this Plan Document or matters that are not adequately covered in the Plan Document and to decide all questions arising in interpretation, including factual determinations relating to eligibility and payment of benefits under the Plan. The Trustees will endeavor to follow uniform rules and guidelines recognizing that the Trustees may change such rules and guidelines from time-to-time, and that the Trustees may use their discretion in applying them. Decisions of the Trustees shall be final and binding on all parties, unless the Trustees action is clearly arbitrary or beyond their authority. All decisions made by the Trustees are intended to be subject to the most deferential standard of judicial review. Benefits under this Plan will be paid only if the Trustees or their designee, the Plan Administrator, decide in their discretion that the individual is entitled to those benefits.

15.2 AMENDMENT OF PLAN DOCUMENT

The Trustees may amend this Plan at any time and to any extent; to the extent allowed by law the amendments may be retroactive. Classes of eligible persons may be changed or eliminated.

No benefits or eligibility are vested. Any benefit or eligibility may be reduced or eliminated.

The ability of the Fund to provide benefits is based upon the financial resources of the Fund that are available in relationship to existing claims and potential claims, therefore, the Trustee retain the right to amend the Plan by reducing any one or more of the benefits payable under the Plan or eliminating one or more of the benefits payable under the Plan. If the Trustees deem it necessary any reduction or elimination shall, to the extent allowed by law, apply to all claims not already paid by the Trustees, even though the event giving rise to the claim may have already taken place. For example: Benefits payable to an Employee or Qualified Dependent already disabled for non-occupational injury may be reduced or a Member who has acquired eligibility that would continue for at least a four month period may have that continuing eligibility reduced, for example, to a two month period. It is not the Trustees' desire to take such drastic action, but they reserve the right to do so should circumstances warrant such action in their judgment.

15.3 MINOR OR INCOMPETENT

If any unassigned benefit under this Plan becomes due to a minor or incompetent, the Trustees may make such payment to a person or institution providing for the minor or incompetent, even though such person is not a court appointed guardian. The Trustees may use their judgment in determining minority or incompetency without a court proceeding on incompetence and as to which of one or more parties contending that they are entitled to payment, should be paid.

Any payments in accordance with this provision shall be a complete discharge of the Trustees' liability to the extent of such payment and the Trustees shall not be obligated to see to the application of the money so paid.

15.4 LEGALITY CLAUSE

If any provisions of this Plan shall be found to be illegal or unenforceable by any Court, such invalidity shall not affect the other provisions of this Plan. The Trustees will then make such amendment to the Plan, as they deem necessary to replace such invalid provision in keeping with the purpose of this Fund.

ARTICLE XVI CLAIM AND APPEAL PROCEDURES

16.1 FILING OF CLAIM

In order to file a "claim" for medical, dental, prescription drug or vision benefits, a request for the payment of benefits that have already been provided by a Physician, Hospital, dentist, pharmacy or other provider must be submitted in writing on an authorized form to the appropriate address shown below in Sec. 16.3, "HOW TO FILE A CLAIM," however claims from Physicians and other providers submitted in electronic format will also be accepted to the extent agreed to by the Fund or required by law.

Claims and appeal procedures for medical, dental, vision, death, dismemberment and accident and sickness benefits are described below. Claims for disability benefits, including accident and sickness benefits and other determinations of disability must be submitted to the Fund Office in writing.

For claims related to prescriptions submitted to a retail or mail order pharmacy, the procedure is different than for medical claims. Submission of a prescription to a pharmacy does not constitute the filing of a claim. If the Member or Qualified Dependent receives a prescription drug from a retail or mail order pharmacy and believes that the co-payment amount charged by the pharmacy is incorrect or that the pharmacy otherwise charged too much, the participant may then submit a written claim to the Fund Office requesting reimbursement of any amounts the Member believes were overcharged.

16.2 TIME LIMIT FOR FILING A CLAIM

All claims for benefits must be filed at the Fund Office, no later than one year following the date of the occurrence of the disability, illness, injury, dismemberment, death, expense or other event giving rise to the claim. Any claim filed after such one-year period shall not be recognized and shall not be paid by the Trustees, unless the Member or beneficiary submits evidence satisfactory to the Trustees that is was not reasonably possible to file the claim within the one year time. In the event of the mental or physical inability of a Member to file a claim hereunder, the Trustees may, in their sole discretion, permit the claim to be filed on his behalf by a relative or third party providing care or services to the Member.

16.3 HOW TO FILE A CLAIM

(a) Medical and Vision

A provider of medical or vision services may submit a claim electronically in accordance with the Electronic Data Interchange (EDI) rules or via a standard industry billing statement that includes the Member's name and identification

number, patient's name, date of service, type of service and amount of charge. Any other person seeking benefits must submit a written claim form to the Fund Office, which includes all of the required information shown above. Claim forms will be supplied upon request by the Fund Office.

Members and Qualified Dependents should always show their identification card at the time services are rendered.

Claims for medical and vision benefits should be submitted to Coventry/CMR Health Care of Missouri, Inc. d/b/a Care Management Resources (Coventry/CMR):

Electronic Claims: Payor ID #25133
Clearinghouse: Endeon

Written Claims:

Health Care of Missouri, an Aetna Company,
d/b/a Care Management Resources
P.O. Box 7817
London, Kentucky 40742-7817

(b) Dental Claims

Dental claims from participating providers should be submitted directly to DDMo by the provider. Written dental claims from non-participating providers and by participants as well as requests for reconsideration of a dental should be submitted to:

Delta Dental of Missouri
Appeals Committee
12399 Gravois Rd
St. Louis, Missouri 63127-1702

Dental claims must be filed by the end of the calendar year following the year in which services were rendered. If a claim is denied due to a PPO or Premier participating dentist's failure to make timely submission, you will not be liable to such dentist for the amount which would have been payable by DDMO, provided you advised the dentist of your eligibility for benefits at the time of treatment.

(c) Prescription Drug Claims

Prescription Drug claims should be submitted electronically by the pharmacy directly to LDI, the Fund's Prescription Benefit Manager (PBM).

(d) Other Claims

Claims submitted by participants for death, dismemberment, accident and sickness, should be submitted to the Fund Office:

SMART Local Union No. 36 Welfare Fund
2319 Chouteau Avenue, Suite 300
St. Louis, MO 63103

A request for a determination of disability by the Plan for continued eligibility must be submitted in writing to the Fund Office within one year following the commencement of disability, unless otherwise noted in this Summary Plan Description. Such requests will be handled as a claim for benefits as described below.

Predetermination related to a Hospital admission, surgical or outpatient procedure, or a Mental Health and Substance Use Disorder (MHSUD) treatment is described in Sec. 6.7 on page 47.

16.4 AUTHORITY OF TRUSTEES TO INVESTIGATE

As a condition of payment of any claim, the Trustees and/or the Fund Office shall have authority to investigate the claim and may seek independent medical advice in ruling on any claim and require such other evidence from the claimant as reasonably needed to decide the claim; the claimant shall authorize the Trustees to have access to any medical reports, records or Hospital, Employers, governments and doctors and shall authorize these and other parties maintaining records to respond to inquiries from the Trustees concerning the claim. If the Trustees deem it appropriate, they may require a claimant to submit to the examination of a Physician or Physicians selected by the Trustees, at the expense of the Trustees.

16.5 CLAIM PROCESSING

The Fund Office will act on the claim within 30 days (45 days for weekly disability income claims or other requests for determination of disability) from the date the claim is received. If additional information is needed or if special circumstances beyond control of the Plan require more processing time, the Fund may extend the processing time for up to 15 additional days (for disability claims processing time may be extended up to two additional 30-day periods).

If the Fund requires an extension of time to process a claim, the claimant will be notified in writing prior to the expiration of the initial 30-day (or 45-day) period. The notice will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, additional information (if any)

needed to resolve those issues and the date by which the Fund expects to render a final decision. If the Fund Office requests additional information, the claimant will have at least 45 days to supply that information and this time will stop the time period the Plan has to reach its decision on the claim until such information is received. Failure to supply requested information within the given time limit will lead to a denial of the claim.

16.6 CLAIM DENIAL

If the Fund Office determines that a person who submits a claim is not entitled to benefits under this Plan or is entitled to a lesser benefit than the amount claimed, then the claimant will be furnished a written statement of the reason or reasons for denial including reference to the Plan provisions on which the denial or reduction is based, a description of any additional material or information necessary for the claimant to establish his right to benefits, and an explanation of why such material or information is necessary. Medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination will be identified without regard to whether the advice was relied upon in making the benefit determination. This written notice will also contain an explanation of the appeal procedure that the claimant can follow to have his claim for benefits reviewed. The statement will be written in a manner calculated to be understood by the claimant.

16.7 APPEAL PROCEDURE

(a) Appeal Mandatory. If any Member, Qualified Dependent, beneficiary, Employer or any other party (including but not limited to an heir, a legatee, or an assignee such as a Hospital) has any complaint with respect to any action, or failure to act of the Trustees, or for failure to pay all or part of a claim or for any other matter whatsoever, an appeal must be filed with the Trustees.

(b) Time Limit for Filing an Appeal. An appeal must be filed in writing at the office of the Fund and signed by the party appealing or by his authorized representative, within 180 days of the receipt by the claimant of the denial notice which the appeal concerns.

(c) Appeal Procedures. A claimant who receives an adverse benefit determination, or his duly authorized representative, has the right to appeal the Fund’s decision to the Trustees by submitting a written statement setting forth issues or comments along with any supporting documents related to his appeal. The written statement must be signed by the claimant or his representative and filed with the Fund Office within 180 days of the receipt by the claimant of the denial notice. Upon request and free of charge, the claimant or his representative may review or obtain copies of documents pertinent to the appeal which are in possession of the Fund, including

any internal guideline, protocol or other criteria on which the original benefit determination was based.

All appeals will be decided by the Trustees. All appeals will be decided by individuals who were neither involved in the original benefit determination nor subordinates of anyone who was involved in the original benefit determination. The appeal determination will be based on all the evidence related to the claim, including evidence and statements submitted by the claimant, even if such information was not considered in the original benefit determination. In considering the appeal, no deference will be given to the initial adverse benefit determination.

If the initial adverse benefit determination was based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigative, or not Medically Necessary or appropriate, the Trustees shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Trustees will decide the appeal no later than the date of the regular Trustees meeting that immediately follows the plan's receipt of the appeal, unless the appeal is received within 30 days preceding the date of such meeting. In such case, a decision will be made no later than the date of the second meeting following the plan's receipt of the appeal. If special circumstances require a further extension of time for processing a decision will be made not later than the third meeting following the plan's receipt of the appeal. If such an extension of time for review is required because of special circumstances, the Plan Administrator will notify the claimant in writing of the extension, describing the special circumstances and the date as of which the appeal will be decided, prior to the commencement of the extension.

16.8 APPEAL DECISION

The Fund Office will notify the Member or claimant in writing of the appeal decision as soon as possible but not later than five business days following the date the decision is made. The notification will include the specific reason(s) for the decision and specific reference(s) to the pertinent Plan provisions on which the decision is based.

The Trustees have the discretionary authority to rule on all appeals and their decisions shall be final and binding on all parties, including but not limited to Employers, unions, participants, Retirees, Qualified Dependents and beneficiaries and their service providers. Benefits will be paid only if the Trustees decide in their discretion that the applicant is entitled to them.

The person or persons deciding the appeal shall have discretion to interpret all documents and other matters pertaining to the appeal, to determine eligibility for benefits, and to exercise such authority as set forth in Sec. 15.1, on page 96.

16.9 LIMITATION ON COURT ACTIONS

If the appeal is denied, the claimant has the right to bring a civil suit under ERISA Sec. 502(a). However, no legal action may be brought to recover on this plan prior to exhaustion of the claims appeals process described above. No such action may be brought after two years from the date the final appeal decision is issued.

16.10 CLAIMS AND APPEALS FOR INSURED LIFE INSURANCE AND ACCIDENTAL DEATH BENEFITS

See the insurance policy for claim and appeal procedures.

16.11 EXTERNAL REVIEW PROCEDURE

The following procedure applies to medical claims. It does not apply to denials of claims for Accident and Sickness Benefits, Death Benefits, or credited hours in relation to disability.

Filing a Request for External Review.

You, your beneficiary, or the authorized representative of you or your beneficiary (all together referred to as "claimant") may file a request for an external review if the request is filed within four months after the date of receipt of a notice of adverse benefit determination or final internal adverse benefit determination (denial of appeal). If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

Preliminary review.
Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether

(a) You or your dependent is or was covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;

(b) The adverse benefit determination or the final adverse benefit determination related to a failure to meet the requirements for eligibility under the terms of the plan (e.g., whether you worked sufficient hours during the eligibility period);

(c) The plan's internal appeal process was exhausted unless exhaustion is not required as set out in this procedure; and

(d) You or your dependent provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Plan will issue a written notification. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, the notification will also describe the information or materials needed to make the request complete. The claimant will be allowed to perfect the an incomplete request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

Referral to Independent Review Organization.

The Plan will assign an independent review organization (IRO) accredited by URAC or similar nationally-recognized accrediting organization to conduct the external review and will take action against bias and to ensure independence by contracting with at least three (3) IROs and rotate claims assignments among them. In addition, the IRO will not be eligible for any financial incentives based on the likelihood that it will support the denial of benefits.

The External Review Process.

The assigned IRO will:

(a) utilize legal experts where appropriate to make coverage determinations under the plan;

(b) timely notify the claimant in writing of the request's eligibility and acceptance for external review.

Within five business days after the date of assignment of the IRO, the Plan will provide the assigned IRO with the documents and any other information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the Plan to timely provide the documents and information will not delay the conduct of the external review. If the plan fails to timely provide the documents and

information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination.

Within ten business days following the date of receipt of notice from the IRO that it has received the request for external review the claimant may submit in writing additional information for the IRO to consider. The IRO is not required to, but may, also accept and consider additional information submitted after ten business days.

Upon receipt of any information from the claimant, the assigned IRO will forward the information to the plan within one business day. Upon receipt of any such information, the plan may reconsider its adverse benefit determination or final internal adverse benefit determination. Reconsideration by the plan, however, will not delay the external review. The external review will be terminated as a result of the reconsideration only if the plan decides to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the plan will provide the claimant and the assigned IRO with written notice of its decision and the assigned IRO will terminate the external review.
The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the plan's internal claims and appeals process.

In addition to the documents and information provided by the Fund and the claimant, to the extent the information or documents are available and the IRO considers them appropriate, the assigned IRO will consider the following:

(a) The claimant's medical records;

(b) The attending health care professional's recommendation;

(c) Reports from appropriate health care professionals and other documents submitted by the Plan, the claimant, or the claimant's treating provider;

(d) The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;

(e) Appropriate practice guidelines, which must include applicable evidence based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

(f) Any applicable clinical review criteria developed and used by the plan, unless the criteria are inconsistent with the terms of the plan or with applicable law; and

(g) The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned IRO will provide written notice of the final external review decision within 45 days after it receives the request for the external review and will deliver the notice of final external review decision to the claimant and the plan within one business day after making the decision. The assigned IRO's decision notice will contain:

(a) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

(b) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(c) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(e) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the claimant;

(f) A statement that judicial review may be available to the claimant; and

(g) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

Reversal of plan's decision.
Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review.
You or your beneficiary or representative may make a request for an expedited external review with the Plan if the claimant receives:

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

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

Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth above and will immediately send the claimant a notice of its eligibility determination. Upon a determination that a request is eligible for external review the plan will assign an IRO and provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. The assigned IRO will provide notice of the final external review decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the plan.

SUMMARY OF
Life Insurance, Dependent Life Insurance and Accidental Death and Personal Loss

Life and accidental death and dismemberment coverage is an insured benefit provided through Aetna Life Insurance Company (ALIC). The following is a summary of the provided. **Payment of benefits is subject to all terms of the life insurance policy and in the case of conflict the insurance policy controls. If you think you are eligible for a benefit described in this summary contact the Fund Office for more information.**

A. Coverage

Life Insurance Coverage

A benefit is payable if you lose your life or a covered dependent loses his or her life while coverage is in effect.

Accidental Death and Personal Loss Coverage

A benefit is payable for certain losses if both of the following occur while your coverage is in effect:

- You are involved in an **accident**; and
- You suffer a bodily **injury** as a direct result of the **accident**.

Who is Eligible for Coverage

Members of Class I, II, III and V

B. Policy Information

Group Policy Number:	GP-838910-GI
Issue Date:	September 15, 2015
Effective Date:	August 1, 2015

C. Schedule of Life Insurance Benefits

Classification	Amount
All Employees	$30,000
Dependents	
Spouse	$15,000
Unmarried child, age 14 days to age 26 (note this is different than the age for medical benefits)	$5,000

D. Accelerated Death Benefit (ADB)
(see page 5 for description of Accelerated Death Benefit)

Benefit available to Employees and Dependent Spouses (not children)

ADB months	24 months
ADB percentage	up to 75%
ADB minimum	$5,000
ADB maximum	up to $500,000

E. Accidental Death and Personal Loss Coverage
Benefit available to Employees and Dependent Spouses (not children)

1. Schedule of Accidental Death and Personal Loss Benefits

Classification	Principal Sum
All Employees	$30,000

The amount of the person's Principal Sum will be based on the amount of coverage in-force on the date of the accident, not the amount that may be in-force at the time of the loss.

2. Additional Accidental Death and Personal Loss Benefits
(see pages 9-10 for description of the following benefits)

Passenger Restraint Benefit Maximum	$10,000
Airbag Benefit Maximum	One half of a person's **Passenger Restraint** Benefit
Education Benefit Maximum for each dependent child	Your actual expenses not to exceed 5% of your, or your spouse's, principal sum or $5,000/year for up to 4 years, whichever is less
for your spouse	Your actual expenses not to exceed 5% of your principal sum or $5,000 per year for up to 4 years, whichever is less
Child Care Benefit Maximum for each child	Your actual expenses not to exceed 3% of your principal sum or $2,000 per year per child for up to 4 years, whichever is less
Repatriation of Remains Benefit Maximum	Your actual expenses up to $5,000

Your Life Insurance Plan

Naming Your Beneficiary
Naming Your Beneficiary
Accelerated Death Benefit

Life insurance is an important component of your financial planning. The Life Insurance Plan pays a benefit to your beneficiary if you die while covered by the plan. Refer to the *Schedule of Life Insurance Benefits* for information about the plan's benefit.

A. Naming Your Beneficiary

A beneficiary is the person you designate to receive life benefits if you should die while you are covered. A beneficiary designation form should be completed, which may be obtained from the Fund office.

If you name more than one primary beneficiary, the life insurance benefits will be paid out equally unless you stipulate otherwise on the form. If you name more than one primary beneficiary and the amount or percentage of the payment to your primary beneficiaries does not equal 100% of your life insurance amount, the difference will be paid equally to your named primary beneficiaries.

You may change your beneficiary choice at any time by completing a new beneficiary designation form and submitting to the Fund Office. The beneficiary change will be effective on the date the Fund Office receives your new signed beneficiary designation form.

You are the only person who can name or change your beneficiary. No other person may change your beneficiary.

If one of your named primary beneficiaries dies before you, his or her share will be payable in equal shares to any other named primary beneficiaries who survive you. If you have named a contingent beneficiary, your contingent beneficiary will only be paid if all primary beneficiaries die before you.

If you have not named a primary or contingent beneficiary, or if the persons you have named all die before you, payment will be made as follows to those who survive you:

- Your spouse, if any.
- If there is no spouse, in equal shares to your children.
- If there is no spouse and no children, to your parents, equally or to the survivor.
- If there is no spouse, children or parents, in equal shares to your siblings.
- If none of the above survives, to your executors or administrators of your estate.

<u>If Your Beneficiary Is a Minor</u>

The method of payment will differ if your beneficiary is a minor or legally unable to give a valid release for payment of any Life Insurance benefit. **Aetna** will issue (as permitted by applicable state law) the life insurance payment to:

- The guardian of your beneficiary's estate; or
- The custodian of the beneficiary's estate under the Uniform Transfer to Minors Act; or
- An adult caretaker/legal guardian.

B. Accelerated Death Benefit

The plan's Accelerated Death Benefit feature allows you to receive a partial life insurance benefit if you, your spouse are:

- Diagnosed with a **terminal illness** and not expected to survive more than the ADB Months; or
- Diagnosed with one of the following medical conditions:
  - Amyotrophic Lateral Sclerosis (Lou Gehrig's disease);
  - End stage heart, kidney, liver and/or pancreatic organ failure and you are not a transplant candidate;
  - A medical condition requiring artificial life support, without which you would die; or
  - A permanent neurological deficit resulting from a cerebral vascular accident (stroke) or a traumatic brain injury which are both expected to result in life-long confinement in a **hospital** or **skilled nursing facility**.

If you may be eligible for the Accelerated Death Benefit or would like more information, contact the Fund office.

C. Dependent Life Insurance

Dependent life insurance pays a benefit to you if one of your covered dependents dies at any time or place. Aetna will pay the benefit per the *Payment of Benefits* section. If you are not living at the time the benefit is paid, the payment will be made to your executors or administrators. **Aetna** has the option to make this payment to your spouse.

The following dependents are ***not*** eligible for dependent life insurance:

- Full-time, active military personnel;
- Children who are married; and
- Children less than 14 days of age.

D. Employee and Dependent Life Suicide Exclusion

The plan will not pay a benefit if you, or your dependent, die by suicide, while sane, or from an intentionally self-inflicted **injury**, within one year from the effective date of your, or your dependent's coverage.

If your, or your dependent's, death occurs after one year of the effective date of your, or your dependent's coverage, but within one year of the date that any increase in coverage becomes effective, no death benefit will be payable for any such increased amount.

Accidental Death and Personal loss Coverage

Covered Losses **Accident Benefits Payable**
Additional Benefits **Exclusions**

Accidental Death and Personal Loss Coverage (ADPL) covers losses you suffer solely and as a direct result of an accidental bodily **injury** that occurs while covered by the plan. Benefits are payable to your beneficiary if you die, or to you if you suffer any other covered loss in an **accident**.

Refer to the *Schedule of Benefits* for additional information about your ADPL benefits.

A. How the Plan Works

Covered Losses

The plan covers a loss you suffer solely and as a direct result of bodily **injury** that happens while you are covered by the plan. The loss must be caused directly, and apart from any other cause, by that bodily **injury** within 365 days after the **accident**. Loss means:

- Loss of life.
- Loss of a hand by actual and permanent severance at or above the wrist joint.
- Loss of a foot by actual and permanent severance at or above the ankle joint.
- Complete and irrecoverable loss of sight in the eye.
- Total and permanent loss of speech or hearing in both ears.
- Loss of the thumb and index finger of the same hand by actual and permanent severance at or above the metacarpophalangeal joint of both fingers.

Loss of speech or hearing is considered permanent if it has lasted for 12 months in a row; unless the attending **physician** states otherwise.

Loss Due to Paralysis

The plan pays a benefit if you are paralyzed solely and as a direct result of an accidental bodily **injury** that happens while covered by the plan. The paralysis must:

- Be caused directly and solely by the bodily **injury**;
- Be complete and irrecoverable; and
- Begin within 30 days of the **accident**.

The following forms of paralysis are covered by the plan:

- Quadriplegia: paralysis of both upper and lower limbs.
- Paraplegia: paralysis of both lower limbs.

- Hemiplegia: paralysis of the upper and lower limbs on one side of the body.
- Uniplegia: paralysis of one limb. A limb means the entire arm or leg.

Exposure

Loss of life caused by exposure to natural or chemical elements will be treated as accidental if the exposure was a direct result of an **accident**.

Disappearance

The plan will pay an accidental death benefit if your body is not found, and no contrary evidence about the circumstances of your disappearance arises, within one year of the accidental disappearance, sinking, or wrecking of a conveyance you occupied.

B. Accidental Death and Personal Loss Benefit Payable

If you die, or suffer a covered loss solely and as a direct result of a bodily **injury** within 365 days of the date of the **accident** causing the **injury**, the plan will pay a benefit. The benefit is expressed as a percentage of the principal sum. The principal sum is the full benefit payable by the plan. The following table defines the benefit payable for each type of loss.

Covered Loss	Percentage of the Principal Sum Paid
Loss of Life -including exposure & presumed disappearance.	100%
Loss of both feet, both hands, or the sight in both eyes	100%
Loss of both speech and hearing in both ears	100%
Loss of one hand, one foot or the sight in one eye	50%
Loss of speech or hearing in both ears	50%
Loss of thumb and index finger of the same hand	25%

Paralysis

If you are paralyzed solely and as a direct result of a bodily **injury**, and the paralysis begins within 30 days of the **injury**, the plan will pay a benefit. The benefit is expressed as a percentage of the principal sum, as shown in the following table:

Covered Loss	Percentage of the Principal Sum Paid
Quadriplegia	100%
Paraplegia or hemiplegia	50%
Uniplegia	25%

Maximum Benefit

The plan will pay up to the principal sum for all losses (including paralysis and **coma**), that result from one **accident**, except as may be provided under Additional Benefits Under the Accidental Death and Personal Loss Plan.

Coma Benefit

The plan will pay a monthly benefit if you suffer an **injury** and are in a **coma** solely and as a direct result of an **accident**, if all of the following occur while covered by the plan:

- The **injury** is caused by an **accident**; and
- You become comatose within 30 days after the **accident**; and
- The **coma** is the direct result of your **accident**; and
- You remain continually **comatose** for at least 30 days in a row.

Written proof that you are in a **coma** must be provided to **Aetna** within 60 days after the date you become comatose.

Covered Loss	Percentage of the Principal Sum Paid By the Plan
Coma for up to 11 months in a row	5% of your principal sum per month
if still comatose in month 12	45% of your principal sum

Third Degree Burn Benefit

The plan will pay a third degree burn benefit if:

- You suffer third degree burns solely and as a direct result of an **accident** covered by this plan; and
- The **accident** occurs while you are covered by the plan.

The benefit payable is based on the principal sum and the extent of the burns.

If the Third Degree Burn Covers:	the benefit payable is:
75% or more of your body	100% of your principal sum
50%-74% of your body	50% of your principal sum

Proof of the nature and extent of the burns must be submitted to **Aetna**.

Total Disability Death Benefit

The plan will pay a benefit equal to the principal sum if you become totally disabled solely and as a direct result of a bodily **injury**, and:

You remain continuously disabled from the date of the **accident** until your death; and you die while you are covered by the plan.

Important Note: For purposes of this benefit provision, you are totally disabled if:

- You are not able to work at your own job;
- You are not able to work at any other job for pay or profit; and

Payment of Benefits

The plan will pay all the benefits, except for loss of life, to you. The benefit for the loss of life will be paid to the beneficiary you named.

Aetna must be notified of your death within 12 months of the date of your death. The payment will be issued to your beneficiary. The amount of the payment will be reduced by any other ADPL payment the plan makes for the same **accident**.

C. Additional Benefits Under the Accidental Death and Personal Loss Plan

This section describes additional losses that may be covered by the ADPL plan if the losses are solely and as a direct result of an **accident**. You must be covered by the plan at the time of the accident that causes the loss and the loss must occur within 365 days of the **accident**. Contract the Fund Office for additional information.

Passenger Restraint and Airbag Benefit

The plan will pay a **passenger restraint** benefit if:

- You are the driver of, or a passenger in, **a motor vehicle**; and
- The **motor vehicle** is involved in an **accident**; and
- You die as a direct result of the **motor vehicle accident**; and
- Death occurs within 365 days of the **accident**; and
- You were properly using a **passenger restraint** at the time of the **accident**; and
- The driver of the car had a valid **motor vehicle** license at the time of the **accident**. The plan will also pay an **airbag** benefit if:
- An **airbag** is activated as the result of the same **motor vehicle accident**; and
- The **airbag** system does not save the life of the person it was designed to protect.

The plan will pay the **airbag** benefit only if you are properly using a **passenger restraint** at the time of the **accident**.

Benefit Payable

The benefit payable depends on whether you were using a **passenger restraint** properly at the time of the **accident** and whether the **airbag** deployed:

At the time of the accident, if you:	**... and the Airbag**	**... the plan will pay:**
Used the **passenger restraint** properly,	Deployed,	**Passenger restraint** and **Airbag benefits**.
Used the **passenger restraint** properly,	Did not deploy,	**Passenger restraint benefit**.
Did not use the **passenger restraint** properly,	Deployed,	No benefit.
Did not use the **passenger restraint p**roperly,	Did not deploy	No benefit.

Aetna must receive verification that:

- You were using the **passenger restraint** system at the time of the **accident**; and
- For the **airbag** benefit, the **airbag** system was activated by the **accident**.

The verification must be part of the official **accident** report or certified, in writing, by the investigating officer(s). Refer to the *Schedule of Benefits* for the benefit payable.

Education Benefit

The education benefit will help provide for your child's education and give your surviving spouse financial help for the cost of employment training if you die as the result of an **accident**.

The plan will pay an education benefit if:

- You die solely and as a direct result of an **accident**; and
- Your death occurs within 365 days of the **accident**.

Education Benefit for Your Dependent Children

Eligible Dependent Children

Your dependent child must meet all the following requirements to be eligible for educational benefits:

- The child is your unmarried:
  - Biological child;
  - Adopted child;
  - Stepchild; or
  - Any other child you support that lives with you in a parent-child relationship;
- The child:
  - Is attending school (school means kindergarten through the 12th grade of high school), or
  - Is past the 12th grade, but under the age of 23; and
  - Is attending college or trade school on a full time basis at the time of your death; or
  - Enrolls in college or trade school on a full-time basis within 365 days after the claim has been approved.

Child Care Benefit

The plan will pay child care benefit for each eligible dependent child if:

- You die solely and as a direct result of an **accident**; and
- Your death occurs within 365 days of the **accident**.
- The child is under the age of 13; and
- The child:
  - Is enrolled in a **legally licensed day care center** on the date of the **accident**; or
  - Is subsequently enrolled in a **legally licensed day care center** within 90 calendar days after the date the claim is approved.

Repatriation of Remains

The plan pays a benefit for the preparation and transportation of your body to a mortuary if you die more than 200 miles from your principal place of residence.

The repatriation of remains benefit is payable if:

- You die solely and as a direct result of an **accident** by this plan;
- Your death occurs within 365 days of the **accident**;
- The accident occurs outside a 200 mile radius from your principal place of residence; and
- An ADPL death benefit is payable.

Refer to the *Schedule of Benefits* for the benefit payable.

Exclusions That Apply to the Accidental Death and Personal Loss Benefit

Not all events which may be ruled accidental are covered by this plan. No benefits are payable for a loss caused or contributed to by:

- Air or space travel. This does not apply if a person is a passenger, with no duties at all, on an aircraft being used only to carry passengers (with or without cargo.)
- Bodily or mental infirmity.*
- Commission of or attempting to commit a criminal act.
- Illness, ptomaine or bacterial infection.*
- Inhalation of poisonous gases.
- Intended or accidental contact with nuclear or atomic energy by explosion and/or release.
- Ligature strangulation resulting from auto-erotic asphyxiation.
- Intentionally self-inflicted **injury**.
- Medical or surgical treatment*.
- 3rd degree burns resulting from sunburn.
- Use of alcohol.
- Use of drugs, except as prescribed by a **physician**.
- Use of intoxicants.

- Use of alcohol or intoxicants or drugs while operating any form of a **motor vehicle** whether or not registered for land, air or water use. A **motor vehicle accident** will be deemed to be caused by the use of alcohol, intoxicants or drugs if it is determined that at the time of the **accident** you or your covered dependent were:
  - Operating the **motor vehicle** while under the influence of alcohol is a level which meets or exceeds the level at which intoxication would be presumed under the laws of the state where the **accident** occurred. If the **accident** occurs outside of the United States, intoxication will be presumed if the person's blood alcohol level meets or exceeds .08 grams per deciliter; or
  - Operating the **motor vehicle** while under the influence of an intoxicant or illegal drug; or
  - Operating the **motor vehicle** while under the influence of a prescription drug in excess of the amount prescribed by the **physician**; or
  - Operating the **motor vehicle** while under the influence of an over the counter medication taken in an amount above the dosage instructions.
- Suicide or attempted suicide (while sane).
- War or any act of war (declared or not declared).

*This exclusion does not apply if the loss is caused by:
- An infection which results directly from the **injury**.
- Surgery needed because of the **injury**.

The **injury** must not be one which is excluded by the terms of this section.

NOTE: These exclusions are in the insurance policy and are not necessarily the same as for medical benefits.

General Information

Continuation of Coverage
Conversion
Reporting of Claims

A. Continuation of Coverage

Handicapped Dependent Children

Life Insurance for your fully handicapped dependent child may be continued past the maximum age for a dependent child. However:
- Life Insurance may not be continued if the child has been issued an individual life conversion policy.
- Life Insurance may not be continued if, at the time you become eligible for dependent coverage under this plan, your child's age has exceeded the maximum age for dependent children under

this plan, even if your child was covered under a prior group plan on the day before this plan takes effect.

Your child is fully handicapped if:

- he or she is not incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon you for support and maintenance, and the mental or physical handicap started prior to the date he or she reaches the maximum age for dependent children under your plan; and
- he or she depends chiefly on you for support and maintenance.

Proof that your child is fully handicapped must be submitted to **Aetna** no later than 31 days after the date your child reaches the maximum age under your plan.

Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Failure to give proof that the handicap continues.
- Failure to have any required exam.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age under your plan.

Aetna will have the right to require proof of the continuation of the handicap during the 2 years following reaching the maximum age under your plan, and once a year thereafter. **Aetna** also has the right to examine your child as often as needed while the handicap continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age under your plan.

Converting to an Individual Life Insurance Policy

Eligibility

You may be eligible to apply for an individual life insurance policy, called a conversion policy, if the group plan coverage for you or your dependents ends because:

- You are no longer in an eligible class; or
- Your coverage amount has been reduced because of the group policy age, pension or retirement reductions. You may also convert your covered dependents life insurance to an individual policy, if:
- You are no longer in an eligible class that is eligible for dependent coverage; or
- Your dependent no longer qualifies as a covered dependent due to age.

Your dependents may convert their coverage as an individual policy if their coverage ends because:

- Your marriage ends in divorce or annulment; or
- You die.

In these circumstances, an application for conversion can be completed and submitted to **Aetna** without providing proof of good health.

Reporting of Claims

You are required to submit a claim to **Aetna** in writing. Claim forms may be obtained from **the Fund Office**.

Your claim must give proof of the nature and extent of the loss. You must furnish true and correct information as **Aetna** may reasonably request.

Reporting of Accidental Death & Personal Loss Claims

In addition to the above, a claim must be submitted to **Aetna** in writing within 90 days after the date of the loss for Accidental Death & Personal Loss Coverage. All claims must give proof of the nature and extent of the loss. Claim forms may be obtained from the Fund Office.

Reporting of Life Insurance Claims

In addition to the above, a claim must be submitted to **Aetna** in writing.

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim may still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims for Accidental Death and Personal Loss Coverages will not be covered if they are filed more than 2 years after the deadline.

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