

**Sheet Metal Workers' Local 73 Welfare Fund
Plan for Retired Members
Summary Plan Description
Plan Benefits as of July 2010**

July 2010

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

4530 Roosevelt Road
Hillside, Illinois 60162
Telephone: 1-708-449-7373
Facsimile: 1-708-449-7333
Facsimile: 1-708-449-7458
Website: www.sm73funds.org

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This booklet contains only highlights of certain features of the Sheet Metal Workers' Local 73 Welfare Fund Plan for Retired Members. Full details are contained in the Plan documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the Plan document language will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.

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To All Eligible Participants:

The Board of Trustees is pleased to present you with this revised booklet that describes the benefits provided to Retired Employees and their Dependents by the Sheet Metal Workers' Local 73 Welfare Fund as of July 2010. This booklet replaces and supersedes all previous Summary Plan Description (SPD) booklets. Separate booklets describe the benefits for Active Plan A and Plan C members and their Eligible Dependents.

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

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

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

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

Best wishes for your good health.

Sincerely,

BOARD OF TRUSTEES

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

- (1) Alter, amend, modify or discontinue the level of benefits, the rate of self-payments, and
- (2) Discontinue the Plan and discontinue the further payments of the Plan at any time.

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

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

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Important Contact Information

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

If You Have a Question or Need Information About	Contact	Phone Numbers and Websites
Eligibility; Benefits, or Medical Claims	Fund Office	1-708-449-7373 www.sm73funds.org
Pre-certification for Hospital Admissions/Inpatient Medical Services	Blue Cross Blue Shield Medical Services Advisory	1-800-255-5192 www.bcbsil.com
Pre-certification for a Mental or Nervous Disorder Service or Substance Abuse	Magellan Client Service Department	1-800-851-7498 www.bcbsil.com
Whether a Provider is part of the BCBS PPO Network	Blue Cross Blue Shield of Illinois	1-800-810-BLUE to Verify if a Provider is PPO Contracted www.bcbsil.com
Dental claims or a list of Network Providers	Delta Dental	1-800-524-0149 www.deltadental.com
Vision claims	EyeMed	1-866-723-0514 www.eyemedvisioncare.com
Retail or Mail Order Prescription Drug Benefits	CVS Caremark	1-800-776-1465 www.caremark.com
Death, or Accidental Death and Dismemberment	Fund Office	1-708-449-7373 www.sm73funds.org
Plan Legal Issues	Fund Office	1-708-449-7373 www.sm73funds.org

Important Benefit Information

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

1. Pre-approval is required for elective or non-emergency hospitalization or elective Inpatient surgery. You must call the Blue Cross Blue Shield Medical Service Advisory (MSA) at least one business day before you go into the Hospital, or within two business days of the date of an emergency admission. You must pay an additional \$250 copayment if you do not call the MSA. See the back of your medical ID card for instructions. You are encouraged, but not required, to contact the MSA for maternity admissions.
2. If you and your spouse become divorced or legally separated, you or your spouse must notify the Fund Office. Your spouse is not eligible for coverage under the Plan as your Dependent as of the date of your divorce or legal separation. Your spouse may be eligible for continuing coverage for 36 months after the divorce or legal separation under COBRA, however. To be eligible for that COBRA coverage, you or your spouse must notify the Fund Office within 60 days of the divorce or legal separation. Please see page 21 or contact the Fund Office if you have any questions about continuing coverage under COBRA.
3. If your Child loses Dependent status under the Plan because your Child no longer meets the Plan's definition of Dependent, you, your spouse, or your Dependent Child must notify the Fund Office within 60 days of the loss of status in order to be eligible for COBRA Continuation Coverage. See page 21 or contact the Fund Office if you have any questions about continuing coverage under COBRA.
4. Certain routine diagnostic tests are covered by the Wellness Benefit. Other tests may be covered if you receive pre-approval by the Fund Office. See page 36 for more details about the tests that are covered under the Wellness Benefit.
5. This Plan coordinates its healthcare benefits (but not prescription drug benefits) with the benefits of any other Plan under which you and your Dependents are covered. If you and/or your Dependents are covered under another plan, you must report all other coverage directly to the Fund Office.
6. Call the Fund Office at 1-708-449-7373 or Blue Cross Blue Shield at 1-800-810-BLUE, or visit the Blue Cross Blue Shield of Illinois website at www.bcbsil.com to find out if a particular provider is a Plan/PPO contracted provider – before you use their services.
7. The fact that your Physician may prescribe, order, recommend or approve a particular service or supply does not make it Medically Necessary or make the expense a covered charge under the Plan. See page 27 for more detailed information about covered medical expenses.

Schedule of Benefits

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

Schedule of Benefits for Non-Medicare Eligible Retirees	
Benefit	Amount
<i>Death Benefit (Retiree Only)</i> ¹	\$15,000
<i>Accidental Death and Dismemberment Benefit (Retiree Only)</i> ¹	
For Your Death	\$15,000
For Two Dismemberments	\$15,000
For One Dismemberment	\$7,500
<i>Wellness Expense Benefit (Retiree and Spouse Only)</i>	
Physical Examination, Smoking Cessation Programs and Certain Tests and Laboratory Work	\$250 for you and your spouse every two calendar years. Deductible and coinsurance do not apply.
<i>Medical Benefit (Retiree and Dependents)</i>	
Comprehensive Major Medical Lifetime Maximum Benefit (including Mental Health Benefits)	\$600,000
Deductible: Individual/Family (not included in your Out-of-Pocket Maximum)	\$350/Maximum of 3 individual deductibles per family each calendar year
Coinsurance (% the Fund Pays for Most Covered Services, Unless Otherwise Specified)	80%
Out-of-Pocket Maximum PPO Provider Non-PPO Provider	\$2,000 per person each calendar year after Deductible is satisfied Not applicable ²
Hospital and Ambulatory Surgical Facilities PPO Facilities Non-PPO Facilities Subject to Pre-Admission Authorization	80% 70% of the Allowable Charge
Copayment for Failure to Obtain Pre-Admission Authorization of Elective Hospitalization, Elective Inpatient Surgery, Dialysis Facility, Skilled Nursing Facility, or Failure to Report Emergency Admission Within 2 Business Days	You must pay an additional \$250 copayment

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

² The Out-of-Pocket Maximum is not applicable for covered expenses received at non-PPO Hospitals or non-PPO Ambulatory Surgical Facilities or for services received from a Non-PPO Physician, or treatment of Mental Health and/or Substance Abuse, or treatment of infertility.

Benefit	Amount
Physician's Services PPO Physicians Non-PPO Physicians	85% 70% of the Allowable Charge
Chiropractic Services PPO Providers Non-PPO Providers Calendar Year Maximum per Person	85% 70% of the Allowable Charge \$1,250
Mental Health Treatment Inpatient PPO Facility Non-PPO Facility Outpatient	Limited to 30 days per calendar year 80% 70% of the Allowable Charge 50% Up to 45 visits per calendar year
Substance Abuse Treatment Inpatient PPO Facility Non-PPO Facility Outpatient	\$15,000 per person per calendar year \$30,000 per person Lifetime Maximum 80% 70% of the Allowable Charge 50%
Infertility Treatment Benefits Coinsurance Combined Lifetime Maximum for You and Your Spouse	50% of covered expenses \$20,000
Organ and Tissue Transplants	Treated the same as other medical expenses. (However, no deductible or coinsurance is applied if you use a Blue Cross Blue Shield Centers of Excellence Facility.)
Hospice Care Benefits Coinsurance Bereavement Counseling Maximum Benefit	No deductible or copayment is required 100% paid by Fund Limited to 6 visits; Maximum of \$50 per visit \$10,000 per person

<i>CVS Caremark Prescription Drug Program</i>	<i>Retail Program</i>	<i>Mail Order Program</i>
You should use the Prescription Drug Program in the following manner:	For immediate or short-term medications	For maintenance or long-term medications
You Pay		
Generic Drug (Per Prescription)	30%	30%
Brand Name Drug – No Generic Available (Per Prescription)	30%	30%
Brand Name Chosen Instead of Available Generic (Per Prescription)	35%	35%
Maximum Supply	34 days	90 days
Refill Limit	As prescribed	As prescribed
Calendar Year Deductible per Person, not included in the Out-of-Pocket Maximum	\$50	
Calendar Year Out-of-Pocket Maximum per Person, After Payment of Deductible	\$2,000	
Calendar Year Out-of-Pocket Maximum per Family, After Payment of Deductible	\$4,000	
Reimbursement of Non-Network Pharmacy Expenses is explained on page 48.		
<i>Dental Benefits</i>	<i>Amount</i>	
Calendar Year Deductible	\$50 per person	
Type of Services		
Preventive Services	45%	
Basic Services	40%	
Major Services	25%	
Dental Anesthesia Services	25%	
Calendar Year Maximum Dental Benefits	\$900 per person	
<i>Optical (Vision) Benefits</i>	<i>Amount</i>	
Lenses, Frames and Eye Examinations	Up to \$225 per person during a consecutive two-year period. The EyeMed program is effective January 1, 2011 and provides additional benefits.	
<i>Hearing Aid Benefit</i>	<i>Amount</i>	
Hearing Aid	Up to \$1,300 per person (\$650 maximum per ear), during a consecutive three-year period	

Schedule of Benefits for Medicare Eligible Retirees	
Benefit	Amount
<i>Death Benefit (Retiree Only)</i> ¹	\$15,000
<i>Accidental Death and Dismemberment Benefit (Retiree Only)</i> ¹	
For Your Death	\$15,000
For Two Dismemberments	\$15,000
For One Dismemberment	\$7,500
<i>Wellness Expense Benefit (Retiree and Spouse Only)</i>	
Physical Examination, Smoking Cessation Programs and Certain Tests and Laboratory Work	Up to the first \$250 for you and your spouse every two calendar years. Deductible and coinsurance do not apply.

Hospice Care Benefits	
Hospice Care Benefits	No deductible or copayment is required
Coinsurance	100% paid by Fund
Bereavement Counseling	Limited to 6 visits; Maximum of \$50 per visit
Maximum Benefit	\$10,000 per person

CVS Caremark Prescription Drug Program	Retail Program	Mail Order Program
You should use the Prescription Drug Program in the following manner:	For immediate or short-term medications	For maintenance or long-term medications
You Pay		
Generic Drug (Per Prescription)	30%	30%
Brand Name Drug – No Generic Available (Per Prescription)	30%	30%
Brand Name Chosen Instead of Available Generic (Per Prescription)	35%	35%
Maximum Supply	34 days	90 days
Refill Limit	As prescribed	As prescribed
Calendar Year Deductible per Person, not included in the Out-of-Pocket Maximum	\$50	
Calendar Year Out-of-Pocket Maximum per Person, After Payment of Deductible	\$2,000	
Calendar Year Out-of-Pocket Maximum per Family, After Payment of Deductible	\$4,000	
Reimbursement of Non-Network Pharmacy Expenses is explained on page 48.		

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

<i>Dental Benefits</i>	<i>Amount</i>
Calendar Year Deductible	\$50 per person
Type of Services	
Preventive Services	45%
Basic Services	40%
Major Services	25%
Dental Anesthesia Services	25%
Calendar Year Maximum Dental Benefits	\$900 per person
<i>Optical (Vision) Benefits</i>	<i>Amount</i>
Lenses, Frames and Eye Examinations	Up to \$225 per person during a consecutive two-year period. The EyeMed program is effective January 1, 2011 and provides additional benefits.
<i>Hearing Aid Benefit</i>	<i>Amount</i>
Hearing Aid	Up to \$1,300 per person (\$650 maximum per ear), during a consecutive three-year period

Non-Medicare Eligible Retirees' Eligibility for Benefits

Eligibility Requirements for Non-Medicare Eligible Retirees

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

- You must be receiving a pension from the Pension Fund that is based on a minimum of ten (10) pension credits,
- If the pension you are receiving from the Pension Fund is based on less than twenty-five (25) pension credits, you must have been credited with a minimum of three (3) pension credits within the period consisting of the Pension Plan year in which you retired and the six consecutive Pension Plan years immediately preceding the Plan Year during which you retired,
- If you served as a full-time officer or business agent of the Union, you will receive credit for the years of service to the Union as if you were receiving Pension Credits for the sole purpose of determining eligibility for coverage under this Plan at the time of retirement; your service as a full-time officer or business agent of the Union will not affect eligibility for welfare coverage upon retirement since contributions are made to the Welfare Fund by the Union for such service, and
- For purposes of determining eligibility for benefits from this Plan, pension credits mean only those pension credits directly awarded by the Pension Fund and do not include pension credits awarded by another pension fund that are taken into consideration in regard to a Reciprocal Pension.

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

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

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

Eligibility Provisions – Non-Medicare Eligible Retirees

Continuation of Eligibility for Non-Medicare Eligible Retirees

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

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

Eligibility for Dependents of Non-Medicare Eligible Retirees

If you are a Non-Medicare Eligible Retiree, your Dependents become eligible for Benefits on the same date you become eligible, or if later, on the date you acquire an eligible Dependent. Eligible Dependents are defined on page 11.

These benefits are subject to Coordination of Benefits rules explained on page 68.

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

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

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

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

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

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

Eligibility Provisions – Non-Medicare Eligible Retirees

- Your eligible spouse or surviving eligible spouse must provide proof of other insurance with the election, and
- If your eligible spouse or surviving eligible spouse does not file an election, your spouse will not be permitted to defer coverage.

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

- Your eligible spouse or surviving eligible spouse must have made a valid election to defer coverage as stated on page 9,
- Your eligible spouse or surviving eligible spouse must have been continuously covered by the health plan of his or her employer since the date that your spouse opted out of this Plan, and provide proof of that coverage,
- Your eligible spouse or surviving eligible spouse must apply to resume coverage with the Fund Office in writing, on or before the 90th day after termination of coverage under the health plan of your spouse's employer. If your spouse does not enroll within this period, your spouse will not be allowed to enroll at a future date, and
- Your eligible spouse or your surviving eligible spouse must make the contributions and payment required by the Sheet Metal Workers' Local 73 Welfare Fund Plan for Retired Members to maintain coverage.

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

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

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

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

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

Your Dependents' Eligibility

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

- The day you begin participation; or

Eligibility Provisions – Non-Medicare Eligible Retirees

- The date you enroll them with the Fund Office.

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

Example: Your Dependent's Eligibility

John becomes eligible for coverage under this Plan on September 1, 2011. John's spouse and his unmarried Dependent Children become eligible on the same date.

Eligible Dependents are defined as follows:

- Your legal spouse; and
- Your unmarried Children who depend on you for more than one-half of their support during the calendar year, maintain a principal residence with you for more than one-half of the calendar year, are younger than you (except for disabled children), and are:
 - Under age 19;
 - Under age 23 if they are full-time students; or
 - Any age if mentally or physically disabled, as long as the mental or physical handicap began before the Child reached age 19 or age 23 if the Child was a full-time student.

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

Children include:

- Natural born Children as of the date of birth;
- Adopted Children (determined as of the time of adoption, or placement with you for adoption); and
- Stepchildren who depend on you for more than one-half of their support during the calendar year, live with you in a regular parent-child relationship, and maintain a principal residence with you for more than one-half of the calendar year.

To enroll your newborn or newly acquired Child, you must provide the Fund Office with a copy of the birth certificate or adoption papers. Dependent status may continue until each Child's 19th birthday or until each Child's 23rd birthday if the Child is a full-time student attending an accredited educational institution. You must provide proof to the Fund Office, at the beginning of each school year (September) and again in February, that the Child is taking at least 12 credit hours per semester to maintain coverage for the Child. The Dependent's benefits terminate when the Child reaches age 19, unless the Fund Office receives proof of student status from an accredited educational institution. If such proof is received, coverage will continue each year until graduation or age 23, whichever comes first.

Eligibility Provisions – Non-Medicare Eligible Retirees

If your Dependent Child is mentally or physically disabled or handicapped and is chiefly dependent on you, Plan benefits will continue as long as your Dependent is disabled or handicapped. To be eligible, your Child must be unable to engage in the normal activities of a person of like gender and age in good health due to disability or handicap. **You must consult the Fund Office within 31 days before Plan benefits might otherwise terminate (at age 19 or 23, if a full-time student) to apply for continued coverage for your disabled or handicapped Dependent Child.**

You must consult the Fund Office within 31 days before Plan benefits might otherwise terminate (at age 19 or 23, if a full-time student) to apply for continued coverage for your disabled or handicapped Dependent Child.

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

If your Child's principal place of residence is not with you, eligibility depends on his or her ability to meet the other non-residence-related requirements above (support and relationship tests) and to meet either of the following conditions:

- For parents who are divorced, separated or who never married:
 - The Child's parents are: 1) divorced or legally separated under a decree of divorce or separate maintenance; 2) separated under a written separation agreement; or 3) live apart at all times during the last six months of the calendar year;
 - The Child's parents provide over one-half of the Child's support;
 - The Child is in the custody of one or both of his or her parents for more than one-half of the calendar year; and
 - The Child is the qualifying child or qualifying relative, as defined in the Tax Code, of one of the parents; or
- You provide over one-half the Child's support and the Child is not a "qualifying child" of any other person.

Effective on and after July 1, 2010, to the extent required by law, if your Dependent Child who is covered under the Plan has full-time student status immediately before the first day of a medically necessary leave, Plan coverage will not end for that Dependent Child due to a medically necessary leave of absence before the date that is the earlier of:

- The date that is one year after the first day of the medically necessary leave of absence; or
- The date on which such coverage would otherwise terminate under the terms of the Plan.

A medically necessary leave of absence means, with respect to a Dependent Child who has full time student status and who meets the conditions of this provision, a leave of absence of such Child from a postsecondary educational institution (including an institution of higher education as defined in Section 102 of the Higher Education Act of 1965), or any other change in enrollment of such Child at such an institution, that:

Eligibility Provisions – Non-Medicare Eligible Retirees

- Begins while the Child is suffering from a serious illness or injury;
- Is medically necessary; and
- Causes the Child to lose student status as a full-time student for purposes of coverage under the terms of the Plan.

For coverage to continue during a medically necessary leave, the Child's treating physician must provide a written certification to the Plan that the Dependent Child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) described above is medically necessary.

You will receive an explanation of this medical leave from the Plan with any request the Plan sends to you for verification of student status for coverage under the Plan.

A Dependent Child whose benefits are continued under this provision will be entitled to the same benefits as if (during the medically necessary leave of absence) the Child continued to have full-time student status at the institution of higher education and was not on a medically necessary leave of absence.

If coverage under the Plan changes (for example, from self-insured to insured), while a Dependent Child is being covered pursuant to a medically necessary leave of absence as described above, then these provisions will apply to the changed coverage of the Dependent Child for the remainder of the period of the medically necessary leave of absence in the same manner as it would have applied to the previous coverage, provided the Plan continues to provide Dependent coverage.

Your Dependents' benefits are subject to the rules outlined in the *Coordination of Benefits* Section on page 68.

Qualified Medical Child Support Order (QMCSO)

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

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

Special Enrollment

This Plan complies with the Federal law regarding special enrollment procedures, as follows. With the exception for a spouse's deferral of coverage explained on page 9, if you are a Non-Medicare Eligible Retiree who is participating in the Plan, and you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll the new Dependent

Eligibility Provisions – Non-Medicare Eligible Retirees

in the Plan. However, you must request enrollment of the Dependent within 30 days after the date you acquire the Dependent.

Certificate of Coverage

When your coverage under this Plan ends, the Fund will provide you with a certificate of coverage that indicates the period of time you were covered under the Plan and certain additional information that is required by Federal law. The certificate will be sent by first class mail within 45 days after your coverage under this Plan ends. If you elect COBRA Continuation Coverage, another certificate will be provided within 60 days after the COBRA Continuation Coverage ends.

The Fund Office will also provide a certificate to you within 45 days if you request the certificate within two years of the date your Plan coverage ended or the date your COBRA Continuation Coverage ended, whichever is later.

Medicare Eligible Retirees' Eligibility for Benefits

Eligibility Requirements for Medicare Eligible Retirees

If you are a Retiree who is eligible to enroll in Medicare, you and your Dependents are eligible for the benefits listed in the *Schedule of Benefits* on page 6. You are not eligible for Weekly Accident and Sickness Benefits, which end on the last day of your coverage under the Sheet Metal Workers' Local 73 Welfare Fund Plan A for Active Members.

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

- The pension that you are receiving from the Pension Fund must be based on a minimum of ten (10) pension credits.
- If the pension you are receiving from the Pension Fund is based on less than twenty-five (25) pension credits, you must have been credited with a minimum of three (3) pension credits within the period consisting of the Pension Plan year in which you retired and the six consecutive Pension Plan years immediately preceding the Plan Year during which you retired.
- If you have served as a full-time officer or business agent of the Union, you will be given credit for the years of service to the Union as if you were receiving Pension Credits for the sole purpose of determining eligibility for welfare coverage at the time of retirement. Service as a full-time officer or business agent of the Union will not affect eligibility for welfare coverage upon retirement since contributions are made to the Welfare Fund by the Union for such service.

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

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

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

Continuing Eligibility for Medicare Eligible Retirees

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

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

Eligibility of Dependents of Medicare Eligible Retirees

Eligible Dependents are defined on page 11. Qualified Medical Child Support Orders (QMCSOs) are explained on page 13. Both the Dependent provisions and QMCSO provisions in the section covering eligibility for Non-Medicare Eligible Retirees also apply to eligibility of Dependents of Medicare Eligible Retirees.

Plan benefits for your Dependents will become effective on the same date you become eligible, or if later, on the date you acquire an eligible Dependent. Benefits for your Eligible Dependents are subject to the Coordination of Benefits provision on page 68.

Termination of Eligibility for Medicare Eligible Retirees and Dependents

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

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

Your Dependents will remain covered by this Plan as long as you meet the continuing eligibility requirements.

Special Enrollment

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

Certificate of Coverage

When your coverage under this Plan ends, the Fund will provide you with a certificate of coverage that indicates the period of time you were covered under the Plan and certain additional information that is required by Federal law. The certificate will be sent by first class mail within 45 days after your coverage under this Plan ends. If you elect COBRA Continuation Coverage, another certificate will be provided within 60 days after the COBRA Continuation Coverage ends.

The Fund Office will also provide a certificate to you within 45 days if you request the certificate within two years of the date your Plan coverage ended or the date your COBRA Continuation Coverage ended, whichever is later.

Enrollment Procedures

Enrollment procedures are as follows:

- **New member:** Complete the Fund's Benefit Enrollment Form, available through the Fund Office.
- **New spouse:** Submit a copy of your marriage certificate and your spouse's birth certificate to the Fund Office when you get married, along with your spouse's social security number.
- **Newborn Child:** Submit a copy of the Child's birth certificate to the Fund Office, along with your Child's social security number.
- **Newly adopted Child:** Submit a copy of the initial placement papers to the Fund Office along with a copy of the birth certificate and adoption papers (when available) , along with your Child's social security number.
- **New stepchild:** Submit a copy of the stepchild's birth certificate and court decree (Qualified Medical Child Support Order) to the Fund Office, along with your Child's social security number.

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

Continuation of Health Benefits

Continuation of Coverage After You Die

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

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

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

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

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

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

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

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

Coverage will terminate for your surviving Dependent Child who continues coverage under the Special Health Coverage Continuation provisions when the Dependent Child no longer meets the definition of Eligible Dependent under the Plan. The Dependent Child may elect COBRA Continuation Coverage for up to 36 months from the date the Child no longer meets the definition of an Eligible Dependent.

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

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

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

Continuation of Coverage for Dependents of Deceased Retirees

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

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

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

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

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

COBRA Continuation Coverage

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

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

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

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

Eligibility for COBRA Continuation Coverage

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

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

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

Scope of COBRA Continuation of Coverage

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

Qualifying Events That Trigger COBRA Continuation Coverage

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

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

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

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

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

Length of COBRA Continuation Coverage

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

Cost of and Payment for COBRA Continuation Coverage

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

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

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

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

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

COBRA Continuation Coverage Notice and Election

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

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

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

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

Your Dependents have an election period of at least 60 days from the date the notice is provided to inform the Fund Office of their election of COBRA Continuation Coverage.

Your Dependents may elect individual coverage or family coverage. Once they make an election for COBRA Continuation Coverage, they cannot change it *unless it is within the 60-day election period*. This means that after the 60-day election period ends, if they elect individual coverage, they cannot change to family coverage (except as explained on page 22), and if they elect family coverage, they cannot change to individual coverage. However, if they elect family coverage for only two family members and one of the family members dies so that individual coverage would be less expensive, the surviving individual may change to individual coverage. The Plan will charge for the individual premium starting on the first day of the month following the day the covered family member dies.

COBRA Benefit Coverage

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

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

Termination of COBRA Continuation Coverage

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

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

When your COBRA Continuation Coverage ends, the Fund will automatically provide a certification of the length of coverage under this Plan. This is called a Certificate of Creditable Coverage and it may help reduce or eliminate any pre-existing condition limitations under a new group medical plan.

If You Have Questions

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

Keep the Fund Informed of Address Changes

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

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

The Fund helps you and your family pay for healthcare expenses as described in this section. If you or your Dependents incur covered expenses during any calendar year, the Plan will pay the percentages of such covered expenses as listed in the *Schedule of Benefits* on page 3. Covered expenses do not include expenses for work-related accidents, Injuries or Sickness.

Preferred Provider Organization (PPO)

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

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

Preferred Provider Organization (PPO)

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

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

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

Calendar Year Deductible

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

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

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

***Comprehensive Major Medical Benefits
For Non-Medicare Eligible Retirees Only***

Common Accident

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

Coinsurance

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

- The amount that the Plan pays of your eligible expenses after you have paid your deductible, and
- Listed in the *Schedule of Benefits* on page 3 as a percentage of your eligible expenses, after the deductible.

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

Out-of-Pocket Maximum

Each calendar year after you reach the out-of-pocket maximum per person listed in the *Schedule of Benefits* on page 3, the Plan generally pays 100% of your remaining covered expenses during that calendar year, except for the following expenses:

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

- Treatment for infertility,
- Treatment received at a non-PPO Hospital or non-PPO Ambulatory Surgical Facility, or treatment received from a non-PPO Physician, and
- Treatment for mental health and/or Substance Abuse.

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

- Deductibles,
- Treatment received at a non-PPO Hospital or non-PPO Ambulatory Surgical Facility, or treatment received from a non-PPO Physician.
- Treatment for mental health and/or Substance Abuse, and
- Treatment for infertility.

Pre-Admission Authorization

When your Physician recommends elective or non-emergency hospitalization or Inpatient surgery, you must call the Blue Cross Blue Shield Medical Service Advisory (MSA) for prior approval of the admission at least one business day before you go into the Hospital. Contact the Blue Cross Blue Shield MSA at 1-800-255-5192.

***Comprehensive Major Medical Benefits
For Non-Medicare Eligible Retirees Only***

If you have an emergency admission, you, your Physician, the Hospital or a family member must call the Blue Cross Blue Shield MSA within two business days of the date of your admission. This provision does not apply to maternity admissions.

If you do not notify the Blue Cross Blue Shield MSA within the required periods of time, you will have to pay an additional \$250 copayment before the Fund will pay any benefits.

You will be required to pay an **additional \$250 copayment** if you do not receive a pre-admission authorization from the Blue Cross Blue Shield MSA.

Services received at the following facilities will be subject to an additional \$250 copayment unless approved by Blue Cross Blue Shield MSA:

- Hospital,
- Dialysis facility, or
- Skilled nursing facility.

Covered Expenses

The Plan provides a wide variety of services and supplies that are Medically Necessary for treatment of non-work related Sickness and Injuries, unless they are excluded or limited by another Plan provision. These include medical care by Hospitals, Doctors and other healthcare Providers, as well as diagnostic tests and procedures used in treatment.

The following expenses are covered under the Comprehensive Major Medical Benefit if they are Allowable Charges, are Medically Necessary (see the *Definitions* Section on page 80) and are services and supplies provided for the treatment of non-occupational Sicknesses or Injuries:

1. Hospital charges for daily board and bed or room, up to the Hospital's regular daily rate for semi-private accommodations. The Plan will cover the expense of a private room if semi-private accommodations are not available.
2. Hospital specialty care unit charges (intensive care unit or cardiac care unit).
3. Charges, other than charges for regular daily services, made by a Hospital for medical care and treatment, exclusive of charges for professional services, including Medically Necessary ancillary services (e.g. prescriptions, supplies).
4. Ambulatory Surgical Facilities expenses.
5. Professional local ambulance service charges for transportation to a Hospital. Transportation by air ambulance is covered if Medically Necessary.
6. Charges made by a licensed Physician for medical care and treatment and for performing a surgical procedure or a laparoscopic procedure.
7. Charges made by a Registered Nurse (RN) during Hospital confinement for private nursing service, provided the attending Physician prescribes in writing the need for services of a registered nurse. In addition, only a coordinated home care program provided by an RN that is Medically Necessary (not custodial-type care) and that replaces or reduces confinement in a Hospital or Skilled Nursing Facility will be covered.

***Comprehensive Major Medical Benefits
For Non-Medicare Eligible Retirees Only***

8. Charges made by a person who is legally licensed as a Licensed Practical Nurse (LPN) during Hospital confinement, provided a registered nurse is not available and the attending Physician prescribes the services of an LPN. In addition, services of an LPN for home care will be covered if the services are Medically Necessary and are rendered under the direction of a Physician or RN.
9. Charges made for the cost and personal administration of an anesthetic by a Physician who remains in constant attendance during a surgical procedure for the sole purpose of rendering an anesthetic.
10. Charges made for the cost and personal administration of an anesthetic by a person legally licensed as a Certified Registered Nurse Anesthetist (CRNA) under the supervision of a Physician who remains in constant attendance during a surgical procedure for the sole purpose of rendering an anesthetic. A Certified Registered Nurse Anesthetist includes a person legally licensed as a Certified Registered Nurse Anesthetist, Registered Nurse Anesthetist, or Nurse Anesthetist, who is authorized to administer anesthesia in collaboration with a Physician, and bill and be paid in the Nurse Anesthetist's own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of the Nurse Anesthetist's license and who is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.
11. Charges made for radium therapy, x-ray treatments and examinations, microscopic tests or any laboratory tests or analyses made for diagnostic or treatment purposes. No benefits will be payable for dental x-rays or x-rays for eye refractions, except in cases of bodily Injury.
12. Charges made for treatment by a person legally licensed as a professional physical, occupational, or speech therapist who acts within the scope of his/her license. Physical, occupational, and speech therapy are benefits that can be subject to medical review. This means that your Physician or you must contact the Fund Office regarding physical, occupational, and/or speech therapy. The Fund Office requires that your Physician provide a letter indicating that the therapy is Medically Necessary, and proposing your treatment plan. The Fund Office will then have the therapy and the length of treatment approved by one of its Contracted Medical Claim Review Providers. Ongoing therapy may also be sent for review by the Plan's Contracted Medical Claim Review Provider.
13. Charges made by a person legally licensed as a doctor of chiropractic medicine (DC) who acts within the scope of his/her license, as provided in the *Schedule of Benefits* on page 4 and subject to a calendar year maximum shown in the *Schedule of Benefits*.
14. Charges made by a person legally licensed as a doctor of osteopathic medicine (DO) who acts within the scope of his/her license, in accordance with the *Schedule of Benefits* on page 4.

If you need to see a Physician:

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

***Comprehensive Major Medical Benefits
For Non-Medicare Eligible Retirees Only***

15. Charges made by a Physician for Inpatient or Outpatient treatment of Mental or Nervous Disorders and/or Substance Abuse not to exceed the maximums shown in the *Schedule of Benefits* on page 4.
16. Charges made by a Dentist for the performance of oral surgery, consisting of cutting procedures for the treatment of diseases or injuries of the jaw or extraction of impacted teeth, provided that such oral surgery is performed during a period of confinement of at least 18 hours in a legally constituted and operating Hospital.
17. Gastric By-Pass Procedures to treat morbid obesity, provided the following criteria are met:
 - a) The patient's Body Mass Index (BMI) is greater than or equal to 50, or
 - b) The patient's Body Mass Index (BMI) is greater than or equal to 45 with two or more co-morbidities that immediately endanger the patient's well-being. Co-morbidities include hypertension, diabetes, dyslipidemia, sleep apnea and coronary heart disease.
 - c) The Gastric By-Pass Procedure must be performed by a PPO Physician at a PPO surgical facility. The Plan will make no payment for Gastric By-Pass Procedures that are performed by a non-PPO Physician or for Gastric By-Pass Procedures that are performed at a non-PPO facility.
18. Rental or, if approved by the Fund Office, the purchase of Durable Medical Equipment (DME) which is Medically Necessary for treatment of a Sickness or disability. To be eligible for coverage:
 - a) The equipment must meet the Plan's definition of (DME).
 - b) The equipment must be ordered by a Physician who must certify the necessity of the equipment and indicate how long the equipment will be needed. This written order must be submitted to the Fund Office and must include a complete diagnosis and treatment plan so the Fund Office can determine whether purchase or rental of the Medically Necessary equipment is more cost-effective.
 - c) You must submit an itemized bill from the company supplying the equipment showing the date the equipment was delivered and the full rental or purchase price.

Only one item of the same or similar DME will be covered during each eligible person's lifetime.

The items listed in Appendix A on page 87 are considered DME or covered supplies for which benefits may be payable if all other conditions to entitlement are satisfied.

The items listed as *Non-Covered* on page 87 are not considered DME or a covered supply.

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

See Appendix A on page 87 for a detailed listing of covered Durable Medical Equipment and a listing of what is not covered.

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

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

Repairs of DME are not considered covered expenses.

19. Radiation therapy and chemotherapy treatments.
20. Renal dialysis treatments are covered if you receive them in a Hospital, a Plan Approved Dialysis Facility or in your home under the supervision of a Hospital or Plan Approved Dialysis Facility.
21. Skilled Nursing Facility Care.
 - a) Admission to a Plan/PPO Skilled Nursing Facility is considered a continuation of your Inpatient Hospital stay and payment will be the same as that previously described for Inpatient covered services.
 - b) If you have been hospitalized, you may continue your recovery as an Inpatient in a Skilled Nursing Facility. You must be admitted for the same diagnosis as the Hospital admission within 14 days of leaving the Hospital or a coordinated home care program.

You should verify that a Skilled Nursing Facility is a Plan/PPO Skilled Nursing Facility before admission.
 - c) Covered services in a Plan/PPO Skilled Nursing Facility include:
 - (i) Bed, board and general nursing care.
 - (ii) Ancillary services (such as drugs and surgical dressings and supplies).
22. Pre-Admission Testing.
23. Human Organ Transplants. Benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ or tissue transplants. Benefits are available to both the recipient and donor of a covered transplant as follows:
 - a) The Fund's deductible and coinsurance provisions do not apply to expenses of covered transplants received at Blue Cross Blue Shield Centers of Excellence facilities.
 - b) If both the donor and recipient have coverage, each will have their benefits paid by their own program.
 - c) If you are the recipient of the transplant and the donor for the transplant has no coverage from any other source, the benefits described in this benefit booklet will be provided for both you and the donor. In this case, payments made for the donor will be charged against the recipient's benefits.

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- d) If you are the donor for the transplant and no coverage is available to you from any other source, the benefits described in this benefit booklet will be provided for you; however, no benefits will be provided for the recipient.
 - e) In addition to the above provisions, benefits for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants will be provided as follows:
 - (i) Benefits under this coverage will begin no earlier than 5 days prior to the transplant surgery and will continue for a period of no longer than 365 days after the transplant surgery. Benefits will be provided for all Inpatient and Outpatient covered services related to the transplant surgery in accordance with the *Schedule of Benefits* on page 4.
 - (ii) Benefits will also be provided for the transportation of the donor organ to the location of the transplant surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada.
 - f) In addition to the other exclusions of this benefit booklet, benefits will not be provided for the following:
 - (i) Cardiac rehabilitation services when not provided to the transplant recipient within 3 days after discharge from a Hospital for transplant surgery.
 - (ii) Transportation by air ambulance for the donor or the recipient.
 - (iii) Travel time and related expenses required by the Provider.
 - (iv) Drugs that are investigational, as determined by Blue Cross Blue Shield of Illinois.
24. Maternity services as follows:
- a) Benefits provided for you and your Dependents including your Dependent Child.
 - b) Benefits for maternity services are the same as benefits for any other condition.
 - c) Benefits will be paid for covered services received in connection with both normal pregnancy and complications of pregnancy. Maternity service benefits will also be provided for the routine Inpatient nursery charges (such as room and board, infant feedings, etc.). Coverage also includes benefits for elective abortions if legal where performed.
 - d) Your Eligible Dependent Child is covered for prenatal and delivery expenses incurred as a result of the birthing process only. No other maternity or newborn charges will be considered covered expenses for your Dependent Child or the newborn Child.
 - e) Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a Cesarean Section. However, Federal law generally does not prohibit the mother's or newborn's attending Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not require that a Provider obtain authorization from the Fund or the

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insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

25. The necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of your newborn Child. In addition, benefits will be payable with respect to expenses incurred as a result of routine nursing care, routine well baby care, immunizations and medical exams or tests.
26. Administration of blood transfusions.
27. Surgical sterilization charges.
28. Routine child and adolescent immunizations and routine Physician examinations or check-ups (until the Child's 23rd birthday) for eligible Dependents.
29. Reconstructive breast surgery and breast prosthesis following a mastectomy including:
 - a) Reconstruction of the breast on which the mastectomy was performed,
 - b) Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
 - c) Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.
30. Hospice expenses, in accordance with the Hospice Benefit on page 34.
31. Infertility treatment including in vitro fertilization (IVF), embryo transfer, artificial insemination (AI), interine embryo lavage, gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), lower tubal transfer and Prescription Drugs related to the treatment of infertility, subject to the limits contained in the *Schedule of Benefits* on page 4.
32. Vision therapy to improve and correct vision problems rendered by an optometrist or orthoptic technician for certain limited conditions. The diagnosis must indicate a structural or physical disorder of the eye or eye muscles, such as:
 - a) Accommodation inability (non-presbyopic),
 - b) Amblyopia (resulting from disuse/exanopsia), and
 - c) Binocular dysfunction, including:
 - (i) Convergence/divergence insufficiency (heterophorias: esophoria and exophoria),
 - (ii) Strabismus, accommodative (heterotropias: esotropia and exotropia), and
 - (iii) Myopia, functional (excessive convergency).
33. Out-of-network emergency claims of an emergency nature will be processed as follows:
 - a) The claim will be sent by the Fund Office to its Contracted Medical Claim Review Provider for re-pricing based on Allowable Charges at the 90th percentile.
 - b) After the claim is re-priced by the Contracted Medical Claim Review Provider, the resulting charges will be processed at the appropriate in-network rate.

Routine immunizations are covered for your Eligible Dependent Children up to age 23.

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- c) Payment of the claim will be based on Allowable Charges at the 90th percentile and paid at the appropriate in-network rate for the initial emergency claim, as well as surgical follow-up care.
34. The first pair of eyeglasses purchased after cataract surgery.

Benefits are limited to services that are Medically Necessary. Certain benefits must be approved by the Blue Cross Blue Shield MSA or the Fund Office and its Contracted Medical Claim Review Provider. In the event the service or procedure is not covered by the *Schedule of Benefits*, it will not be covered.

Hospice Benefit

The Hospice Benefit covers 100% of Allowable Charges for the services outlined in the following chart up to a lifetime maximum shown in the *Schedule of Benefits* on page 4.

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

Schedule of Benefits for Hospice Services

Home Hospice Care - Allows patient to receive care in his or her own home.

Services and equipment covered at 100% include:

- Physician services,
 - Physical, respiratory and occupational therapies,
 - Drugs, medications and medical supplies when provided under the Hospice Care Program through Hospice Care Agency,
 - Private duty nursing services by a Registered Nurse or Licensed Practical Nurse, if certified by a Physician,
 - Rental of Durable Medical Equipment (DME), as described in Appendix A on page 87, and
 - Oxygen and rental of related equipment.
-

Outpatient Hospice Care – Care that you receive in a licensed medical facility. After you receive treatment, you return to your home.

Services covered at 100% include:

- Physician services,
 - Laboratory, x-ray and diagnostic testing, and
 - Ambulance service or alternative types of transportation.
-

Inpatient Hospice Care – Care received while you are an admitted patient in a Hospital or Hospice facility.

Services covered at 100% include:

- Room and board which may include overnight visits by family,
 - Nursing services,
 - All other related Hospital expenses,
 - Physician services, and
 - Ambulance service or alternative types of transportation.
-

Other Services – In addition to the services outlined above, certain other services for you and your family are also covered.

Services covered at 100% include:

- Visits by a licensed social worker to evaluate the social, psychological and family problems related to the terminal illness. In addition, this professional will help develop a plan to assist in resolving these problems;
 - Emotional support services to help relieve stress, cope with the anticipated loss, complete unfinished family business and maintain the patient in the most appropriate environment;
 - Special incidental services for the patient, such as special dietary requirements, transportation between home and other sites of care; and
 - Bereavement counseling for the immediate family following the death of the Hospice patient. (Coverage is limited to six visits at a maximum expense of \$50 per visit.)
-

Wellness Expense Benefit (Retiree and Spouse Only)

Every two calendar years, the Fund will pay wellness benefits up to the amount listed in the *Schedule of Benefits* on page 3 for you and your spouse. These benefits include:

- Physical examinations,
- Blood tests,
- Pap Smears,
- X-rays,
- Mammograms,
- EKGs,
- Smoking cessation programs, and
- Other routine services and covered supplies that contribute to maintaining your wellness, if approved in advance by the Fund Office, and are not covered elsewhere under the Plan. A request for such pre-approval constitutes a pre-service claim. See the *Pre-service Claims* section on page 63.

The Plan covers a variety of wellness expenses for you and your spouse up to the limits provided in the *Schedule of Benefits*.

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

Wellness benefits are provided only for you and your spouse and are not provided for your Dependent Children. However, Inpatient nursery charges, Physician office visits and immunizations are covered under the Comprehensive Major Medical Benefit for your eligible Dependent Children up to age 23. See page 32.

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

Dental Benefits (Retirees and Dependents)

The Fund provides you and your Dependents with coverage for dental services as outlined in the *Schedule of Benefits* on page 5 or 7. You must satisfy your calendar year deductible before the Fund pays its percentage of your covered dental benefits.

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

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

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

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

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

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

Predetermination of Benefits

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

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

This Predetermination of Benefits is a convenience to let you know in advance what portion of the cost of your dental treatment will be your responsibility. Delta Dental will respond directly to your Dentist with its decision as to whether or not the dental

treatment will be covered and how much will be paid. The Predetermination of Benefits is also available if your Dentist is not participating in the Delta Dental Plan.

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

Covered Dental Services

Class I Benefits – Preventive Services

- **Diagnostic and Preventive Services:** Services and procedures to evaluate existing conditions and/or to prevent dental abnormalities or disease. These services include examinations, prophylaxes, and fluoride treatments.
- **Emergency Palliative Treatment:** Emergency treatment to temporarily relieve pain.
- **Radiographs:** X-rays as required for routine care or as necessary for the diagnosis of a specific condition.
- **Recent Crowns.**

Class II Benefits – Basic Services

- **Endodontic Services:** The treatment of teeth with diseased or damaged nerves (for example, root canals). Excludes apicoectomy.
- **Minor Restorative Services:** Minor services to rebuild and repair natural tooth structure when damaged by disease or Injury. Minor restorative services include amalgam (silver) and resin (white) fillings.
- **Emergency and Specialty Exams.**

Class III Benefits – Major Services

- **Oral Surgery Services:** Extractions and dental surgery, including preoperative and postoperative care.
- **Periodontic Services:** The treatment of diseases of the gums and supporting structures of the teeth. This includes periodontal maintenance following active therapy (periodontal prophylaxes). Actisite is a covered benefit.
- **Relines and Repairs:** Relines and repairs to crowns, bridges, partial dentures, and complete dentures.
- **Major Restorative Services:** Services to rebuild and repair natural tooth structure when damaged by disease or Injury, such as crowns, used when teeth cannot be restored with another filling material.
- **Prosthetic Services:** Services and appliances that replace missing natural teeth (such as bridges, partial dentures, and complete dentures).
- **Veneers – Labial Veneers –** (cosmetic bonding).
- **Apicoectomy – Periradicular Surgery.**

- **Dental Anesthesia:** Dental anesthesia is payable at 50%, subject to the deductible and calendar year maximum. General anesthesia/IV sedation is a covered charge only if there is demonstrated medical need, including the following:
 - Toxicity to local anesthetic,
 - Severe disability, spastic or severe behavioral problems,
 - Prolonged or severe surgical procedure (includes removal of impacted tooth-soft tissue, removal of impacted tooth – partial bony, removal impacted tooth – completely bony impacted, surgical removal of residual tooth roots (cutting procedure),
 - Extractions in two or more quadrants,
 - Acute infection around the injection site,
 - Failure of local anesthesia to control pain, or
 - Subject is under four years of age.

Dental Service Limitations

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

1. Four bitewing X-rays are payable once in any calendar year. Full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period. A panoramic X-ray (including bitewings) is considered a full mouth X-ray.
2. Prophylaxes and oral exams are payable twice in any calendar year. Two additional periodontal prophylaxes are payable per calendar year for individuals with a documented history of periodontal disease. Preventive fluoride treatments are payable once per calendar year for Dependent Children until their 19th birthday.
3. A space maintainer is a covered benefit for patients up to the age of 16.
4. Cast restorations (including jackets, crowns, inlays and onlays) and associated procedures (such as core build-ups and post substructures) on the same tooth are payable once in any five-year period.
5. A crown, inlay, or onlay is a covered benefit only for extensive loss of tooth structure due to caries and/or fracture.
6. An individual crown over an implant is payable at the prosthodontic benefit level.
7. Porcelain, porcelain substrate, and cast restorations are not payable for Children younger than 12 years of age.
8. A stayplate is a covered benefit only for the replacement of permanent anterior teeth during the healing period or for missing anterior permanent teeth for Dependent Children 16 years or younger.
9. Prosthodontic (Class III) benefit limitations:
 - a) One complete upper and one complete lower denture are benefits once in any five-year period for any individual.

- b) A removable partial denture or fixed bridge for any individual can be covered once in any five-year period, unless the loss of additional teeth requires the construction of a new appliance. Fixed bridges are covered only for Participants 16 years or older.
 - c) A reline or the complete replacement of denture base material is limited to once in any three-year period per appliance.
 - d) A soft reline is limited to once in any three-year period.
 - e) Root planing benefits are payable once per year.
10. The Plan's obligation for payment of benefits ends on the last day of the month in which coverage is terminated. However, the Plan will make payment for covered services provided on or before the last day of the month in which coverage is terminated, unless otherwise specified.
 11. When services in progress are interrupted and completed later by another Dentist, Delta Dental will review the claim to determine the amount of payment, if any, to each Dentist.
 12. Care terminated due to the death of a Participant will be paid to the limit of the Fund maximum for the services completed or in progress.
 13. Optional treatment: If the Participant chooses a more expensive service than is customarily provided or for which the Plan or Delta Dental does not determine a valid dental need is shown, the Plan or Delta Dental can make an allowance based on the fee for the customarily provided service.

For example, if the Participant chooses an overdenture, the Fund will pay only the applicable amount that it would have paid for a conventional denture.
 14. Maximum Payment: The maximum benefit payable in any one calendar year will be limited to the amount specified in the *Schedule of Benefits* on page 5 or 7.
 15. The Plan and Delta Dental will not be obligated to pay for any services to which the deductible applies until the Plan deductible amount is met.
 16. Processing policies, such as periodic limitations on certain services, may limit treatment.

Services Not Paid by the Plan

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

1. Amalgam and resin restorations are payable once within a 24-month period, regardless of the number or combination of restorations placed on a surface.
2. Cores and other substructures are covered benefits only when needed to retain a crown on a tooth with excessive breakdown due to caries and fractures.
3. Recementation of a crown, onlay, inlay, space maintainer, or bridge within six months of the seating date or within 12 months of payment for a recementation.
4. Retention pins are benefits once in a 24-month period. Only one substructure per tooth is a covered benefit.
5. Benefits for periodontal surgery, including subgingival curettage, is payable once in any three-year period.

6. A complete occlusal adjustment is a covered benefit once in a five-year period. The fee for a complete occlusal adjustment includes all adjustments that are necessary for a five-year period. A limited occlusal adjustment is not a covered benefit more than three times in a five-year period. The fee for a limited occlusal adjustment includes all adjustments that are necessary for a six-month period.
7. Tissue conditioning is not a covered benefit more than twice per arch in 36 months.
8. The allowance for a denture repair (including reline or rebase) will not exceed one-half the fee for a new denture.
9. More than one root planing per year.

Dental Exclusions

In addition to the General Exclusions and Limitations listed beginning on page 53, the Fund does not cover any loss under the Dental Expense Benefits caused by, incurred for or resulting from the following excluded charges. All charges for the following services will be your responsibility, although your payment obligation may be satisfied by insurance or some other arrangement for which you are eligible:

1. Services, as determined by the Fund, for correction of congenital or developmental malformations, cosmetic surgery, or dentistry for cosmetic aesthetic reasons including repair to facings posterior to the second bicuspid position.
2. Prescription drugs (except intramuscular injectable antibiotics), premedications, medicaments/solutions, and relative analgesia. Medicines or drugs that can be obtained without a Dentist's prescription.
3. General anesthesia and/or intravenous sedation for restorative dentistry (or for surgical procedures) except as provided under Class III Benefits on page 38.
4. Acupuncture, acupressure or hypnosis.
5. Charges for hospitalization, laboratory tests and histopathological examinations.
6. Treatment performed by anyone other than a Dentist, except for services performed by a licensed Dental Hygienist under the scope of his or her license.
7. Services that are covered under the Major Medical or Prescription Drug Benefits.
8. Fluoride rinses, self-applied fluorides or desensitizing medicaments.
9. Preventive control programs (including oral hygiene instructions, caries susceptibility tests, dietary control, tobacco counseling, home care medicaments, nutritional guidance, etc.).
10. Sealants.
11. A space maintainer for maintaining space due to the premature loss of the anterior primary teeth.
12. Lost, missing, or stolen appliances of any type and replacement or repair of orthodontic appliances or space maintainers.
13. A prefabricated crown used as a final restoration on a permanent tooth.

14. Appliances, surgical procedures, and restorations for: increasing vertical dimension; altering, restoring, or maintaining occlusion; replacing tooth structure loss resulting from attrition, abrasion, or erosion; or implantology techniques or periodontal splinting.
15. A substructure to a single/abutment crown over an implant.
16. A paste-type root canal filling on a permanent tooth.
17. Occlusal guards.
18. Chemical curettage.
19. Services associated with overdentures.
20. Acusil, flexiplast or similar partial denture.
21. A metal base on a removable prosthesis.
22. The replacement of teeth beyond the normal complement of teeth.
23. Personalization/characterization of any service or appliance.
24. Temporary appliances.
25. Precision attachments.
26. Implants and implant-related services.
27. Appliances, restorations or services for the diagnosis or treatment of disturbances of the temporomandibular joint dysfunction (TMJ or TMD).
28. Myofunctional therapy.
29. Mounted case analysis.
30. The replacement or alteration of full or partial dentures or fixed bridgework, unless the charge is required due to one of the following events and if the replacement or alteration is completed within 12 months after the event:
 - a) An Injury requiring surgery; or
 - b) Oral surgery treatment involving the repositioning of muscle attachments or the removal of a tumor, cyst, torus or redundant tissue; or
 - c) Replacement of a full denture, unless required as the result of structural change within the mouth and unless made more than five years after the installation of the denture.
31. Orthodontic treatment for you and your spouse or Dependent Child.
32. Charges for failure to keep a scheduled visit with the Dentist.
33. Services, as determined by Delta Dental, for which no valid dental need can be demonstrated, that are specialized techniques, or that are experimental or investigational in nature as determined by the standards of generally accepted dental practice.
34. Those benefits excluded by the policies and procedures of Delta Dental including the processing policies.
35. Services or supplies for which no charge is made, for which you are not legally obligated to pay or for which no charge would be made in the absence of Delta Dental coverage.
36. Services or supplies received as a result of dental disease, defect or Injury due to an act of war, declared or undeclared.

37. Services that are not within the classes of benefits that have been selected and that are not in the contract.
38. Replacement, repair, relines or adjustments of occlusal guards.

Dental Charges Not Paid by the Fund or Delta Dental

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

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

19. Temporary crowns.
20. Local Anesthesia, except as provided under Class III Benefits on page 39.

Extension of Dental Benefits

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

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

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

Optical Benefits (Retirees and Dependents)

To help you with vision care, the Fund pays Optical Benefits up to the maximum amount shown in the *Schedule of Benefits* on page 5 or 7 during a **consecutive two-year period** for the following:

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

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

Effective January 1, 2011 the Trustees have contracted with an optical PPO, EyeMed Vision Care, that provides first dollar benefits up to the maximum in the applicable Schedule of Benefits. Because EyeMed provides discounts for eye examinations, lenses and frames, your benefit amount will go further. You do not have to submit a vision claim form, but you will be required to pay the EyeMed Provider for any cost over your maximum when you pick up your glasses or contact lenses. The benefits provided by EyeMed Vision Care are summarized as follows, subject to all terms and conditions of the EyeMed Vision Care program which are subject to change. Additional discounts and exclusions apply. Contact EyeMed for details.

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

Vision Care Services	Member Cost	Out-of-Network
Exam with Dilation as Necessary	\$0 Copay	Up to \$45
Frames, Lens & Options Package (Any frame, lens and lens options available at provider location.)	\$300 Allowance for frame, lens and lens options; 20% off balance over \$300	Up to \$180
Contact Lenses - Declining Balance*		
Conventional	\$0 Copay, \$180 allowance; 15% off balance over \$180	Up to \$180
Disposable	\$0 Copay, \$180 allowance; plus balance over \$180	Up to \$180
Medically Necessary	\$0 Copay, Paid-in-Full	Up to \$180
Laser Vision Correction Lasik or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	N/A
Additional Pairs Benefit:	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Frequency:		
Examination	Once every 24 months	
Frame & Lenses or Contact Lenses	Once every 24 months	

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

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

In addition to the exclusions listed in the *General Exclusions and Limitations* section on page 53, the Fund will not pay optical benefits for routine yearly examinations required by an employer in connection with your occupation.

Hearing Aid Benefit (Retirees and Dependents)

The Fund provides coverage for you and your Dependents for hearing aid devices. Maximums are shown in the applicable *Schedule of Benefits* on page 5 or 7. Payment will be made for a hearing aid device only if:

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

The Fund does not cover the cost of a hearing examination.

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

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

Call HearPO at 1-888-HEARING
for help finding a network Provider.

To contact HearPO for the name of a participating audiologist or Physician in your area, call their toll-free number at 1-888-HEARING (1-888-432-7464). Please note that you remain free to visit any audiologist or Physician you choose regardless of whether or not they are part of the HearPO network.

Prescription Drug Benefits (Retirees and Dependents)

The Plan provides Prescription Drug Benefits for you and your Dependents for drugs and/or medicines that are prescribed by your Physician. The Plan will pay the cost of the prescription, less any copayment after you have paid your calendar year deductible. The copayments and deductible are listed in the applicable *Schedule of Benefits* on page 5 or 6.

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

Retail Pharmacy Network

Acute medications should be filled at a participating network pharmacy. The retail pharmacy network is offered through CVS Caremark Prescription Service. To find out whether a particular pharmacy is a participating network pharmacy, call a CVS Caremark customer service representative at 1-800-776-1465 or visit the CVS Caremark website at www.caremark.com.

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

Use a network retail pharmacy for an emergency or one-time prescription and the mail order service for a long-term prescription.

To fill this type of prescription simply:

1. Obtain a newly written prescription for each acute medication,
2. Take the prescription to a participating CVS Caremark network pharmacy,
3. Identify yourself as an eligible Local 73 Welfare Fund Participant (for instance, by showing your prescription drug plan CVS Caremark ID card), and
4. Pay the required copayment and any deductible as shown in the *Schedule of Benefits* on page 5 or 6 and you will receive the prescription drug with no additional paperwork or charge.

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

You may obtain a CVS Caremark Claim Form by calling CVS Caremark at 1-800-776-1465, visiting their website at www.caremark.com, or contacting the Fund Office.

Mail Order Prescription Drug Service

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

To fill a maintenance prescription through CVS Caremark, simply:

1. Obtain a new written prescription for each covered medication. CVS Caremark can only dispense the amount of medication your Physician has prescribed up to a 90-day supply.

Show your Physician the material attached to the Prescription Drug Benefits brochure to help him or her write a prescription for this program.

2. Complete the Mail Service Order Form/Patient Profile.
3. Mail the written prescription, the profile, the order form and your copayment to CVS Caremark in the pre-addressed envelope. The copayment for each prescription order is shown in the applicable *Schedule of Benefits* on page 5 or 6. If you need assistance determining the copayment amount, call CVS Caremark at 1-800-776-1465 or visit their website at www.caremark.com.

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

If you have a question about your prescription, call CVS Caremark at 1-800-776-1465. Customer Service Representatives will be available to answer questions weekdays from 7:30 a.m. - 9:00 p.m. and Saturdays from 8:00 a.m. - 12:00 p.m. Central Standard Time.

Prescription Drug Exclusions and Limitations

Benefits are not payable under Prescription Drug Benefits for:

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

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

8. Anabolic steroids,

9. Antiviral drugs used for influenza (flu) treatment or prevention,
10. Weight control or drugs or anorexians, except those used for treatment of Children with attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD) or individuals with narcolepsy,
11. Serum allergy antigen solutions, and
12. Existing and new drugs that are not uniformly and professionally endorsed by the general medical community for prescription in the course of standard medical care, including existing and new drugs that are experimental in nature.

Prescription Drug Benefits Coordination with Medicare Part D

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

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

Death Benefit (Retirees Only)

The Fund provides a benefit for your survivors or your Beneficiary in the event of your death. Your Beneficiary does not need to submit a claim form, but must submit a certified copy of your death certificate. After the Fund Office receives the official death certificate showing that you have died, the Fund will pay your Beneficiary the amount shown in the applicable *Schedule of Benefits* on page 3 or 6.

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

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

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

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

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

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

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

Accidental Death and Dismemberment Benefits (Retirees Only)

If you suffer any of the losses described below as a result of Sickness or bodily Injury, the Fund will pay the amount specified in the applicable *Schedule of Benefits* on page 3 or 6. You must submit a letter from your Physician for accidental dismemberment benefits. If the claim is for your accidental death, your Beneficiary need only submit a certified copy of your death certificate.

Covered losses include:

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

Accidental Death Benefits will be paid if you die as a direct result of bodily Injury caused solely by an accident and you die within ninety days from the date of the accident. No more than the amount listed in the *Schedule of Benefits* on page 3 or 6 will be paid for losses resulting from any one event. Benefits for Accidental Death will be paid to the Beneficiary you have named to receive your Death Benefits, in the order provided on page 51.

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

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

General Exclusions and Limitations

Benefits are not provided under the Plan for the following:

1. Any bodily Injury or Sickness arising out of or in the course of employment or which is compensable under any Workers' Compensation or Occupational Disease Act or law.
2. Any treatment or service not prescribed by a legally qualified Physician or Surgeon to be Medically Necessary.
3. Any charges made by a Hospital unless the hospitalization is recommended and approved by a Physician.
4. Surgery or medical treatment to improve or preserve physical appearance but not physical function. Cosmetic Surgery or treatment includes, but is not limited to removal of tattoos, breast augmentation, or other medical or surgical treatment intended to restore or improve physical appearance. The Plan does cover Medically Necessary reconstructive procedures which are necessary to correct damage caused by a congenital birth defect or an Injury, as provided in Item 25 under *Covered Expenses* on page 32. The Plan does cover reconstructive surgery after a mastectomy, as provided in Item 29 under *Covered Expenses* on page 32.
5. Dental care and treatment except (a) that necessitated by bodily Injury to sound, natural teeth or (b) as specifically provided under the Dental Expense Benefits.
6. Eye examinations and eyeglasses except as provided under the Optical Benefits. However, the first pair of glasses purchased after cataract surgery is paid under the Major Medical Benefit.
7. Routine physical examinations and immunizations, except as specifically provided under the Wellness Benefit for the Retiree and spouse, and except for routine child and adolescent exams and immunizations provided until age 23 for eligible dependents.
8. A bodily Injury or Sickness caused by war or by any act of war, declared or undeclared, or by participating in a riot or as the result of the commission of a felony by an eligible person, except that the Plan will cover Injuries and Sickness resulting from domestic violence.
9. Expenses for services provided without charge to the covered individual under any government-provided plan or program (including, without limitation, TRICARE (formerly known as CHAMPUS) and VA programs) established under the laws or regulations of any government, including the federal, state, or local government or the government of any other political subdivision of the United States, or of any other country or any political subdivision of any country; or under any plan or program in which any government participates other than as an Employer, unless the governmental program provides otherwise.
10. Medical expenses incurred by any covered individual arising from an attempt at suicide or from a self-inflicted Injury or Sickness, including complications from the attempt, unless the action arises as a result of a physical or mental health condition.
11. Charges made by a Physician, Registered Nurse (RN), Licensed Practical Nurse (LPN), Physiotherapist or any other Provider who is related to you or your Dependent or who ordinarily resides with you or your Dependents.

12. Charges made for Outpatient treatment of Mental or Nervous Disorders and/or Substance Abuse, unless provided by a Psychiatrist, Psychologist, Mental Health Counselor, Substance Abuse counselor, or Social Worker with a master's degree or higher who is:
 - a) Legally licensed or legally authorized to practice or provide care or treatment for such conditions under state law or the jurisdiction where the services are rendered;
 - b) Acting within the scope of that license, and
 - c) Not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.
13. Charges exceeding the maximums shown in the *Schedule of Benefits* on page 4 for Outpatient or Inpatient treatment of Mental or Nervous Disorders and/or Substance Abuse.
14. Expenses for naturopathic, naprapathic, and/or homeopathic services or treatments/supplies. Expenses for chelation therapy, except as Medically Necessary for the treatment of acute arsenic, gold, mercury, or lead poisoning, and for diseases due to clearly demonstrated excess of copper or iron.
15. Expenses for medical or surgical treatment of weight-related disorders and obesity (except as provided in Item 17 on page 29), including but not limited to: gastric by-pass procedures, intestinal bypass and reversal procedures, weight loss programs, dietary instructions, Prescription Drugs and any complications thereof, even if those procedures are performed to treat a co-morbid or underlying condition.
16. Charges for smoking cessation programs, treatments or devices, except as provided under the Wellness Benefit.
17. Medicines or drugs that can be obtained without a Physician's prescription.
18. Foods and nutritional supplements including, but not limited to: home medications, formulas, foods, diets, vitamins, herbs and minerals (whether over the counter or prescription) except when provided during hospitalization.
19. Expenses related to prevention of pregnancy including but not limited to: drugs or medicines such as birth control pills, emergency contraceptives; devices, such as condoms, intrauterine device (IUD) or diaphragm; and implantable birth control devices such as Norplant. However, Medically Necessary contraceptives may be covered if approved by the Fund's Contracted Medical Claim Review Provider, and if used to treat a specific medical condition.
20. Any expense or charge for the promotion of fertility, except as provided in the applicable *Schedule of Benefits* on page 4 and Item 31 on page 32. Expenses not covered for the promotion of fertility include, but are not limited to the following:
 - a) Reversal of voluntary sterilization,
 - b) Payment of medical services rendered to a surrogate for purposes of childbirth,
 - c) Costs associated with CRYO preservation and storage of sperm, eggs and embryos. However, procedures which use the CRYO preserved substance may not be excluded,
 - d) Selected termination of an embryo. However, if the life of the mother would be in danger if all embryos were carried to full term, termination is covered,
 - e) Non-medical cost of an egg or sperm donor,

- f) Travel costs not Medically Necessary, or
 - g) Experimental infertility treatments. However, if an infertility treatment includes elements not experimental in nature along with those that are, the non-experimental services are covered as long as they are listed in the applicable *Schedule of Benefits* on page 4 and Item 31 on page 32.
21. Genetic testing and counseling including:
- a) Pre-parental genetic testing intended to determine if a prospective parent or parents have chromosomal abnormalities that are likely to be transmitted to a child; and
 - b) Prenatal genetic testing intended to determine if a fetus has chromosomal abnormalities that indicate the presence of a genetic disease or disorder and performed using fluid or tissue samples obtained through amniocentesis, chorionic villus sampling (CVS), fetoscopy and alphafetoprotein (AFP) analysis in pregnant women. However, amniocentesis is covered if recommended by the patient's Physician.
22. Any expense or charge for orthoptics, eye exercises or vision training and supplies, except as provided under the covered expenses.
23. Vision therapy and orthoptics for perceptual or visual motor coordination problems due to conditions such as minimal brain dysfunction, integrative dysfunction, dyslexia, etc. and problems with the interpretation of visual input to the brain and the reaction and output of the brain in response to such stimuli.
24. Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums and/or facilities for physical fitness programs, including exercise equipment.
25. Expenses for construction or modification to a home, residence or vehicle required as a result of Injury, Sickness or disability, including without limitation: construction or modification of ramps, elevators, chair lifts, swimming pools, spas, air conditioning, asbestos removal, home traction unit, air filtration, handrails, emergency alert system, etc.
26. Any expense for a mechanical heart implant.
27. Foot care treatment for:
- a) Weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, except open cutting operations, and
 - b) Corns, calluses or toenails, except the removal of nail roots and routine foot care from a podiatrist for individuals with diabetes or a neurological or vascular disorder affecting the feet.
28. Rest cures, domiciliary care, convalescent care or custodial care, which is care provided primarily for convenience or to assist the patient in the activities of daily living when the constant attention of trained medical personnel is not required. Also excluded are expenses for the services of private duty nurses, except when Medically Necessary.
29. Acupuncture, acupressure or hypnosis, unless performed by a licensed Physician for a Medically Necessary reason.
30. Non-surgical treatment of the temporomandibular joint dysfunction (TMJ or TMD).

31. Expenses for hair removal or hair transplants and other procedures to replace lost hair or to promote the growth of hair, including prescription and non-prescription drugs such as Minoxidil, Propecin, Rogaine, Vaniga; or for hair replacement devices including, but not limited to wigs, toupees, and/or hairpieces or hair analysis (regardless of diagnosis).
32. Rehabilitation therapy expenses including expenses for:
 - a) Education, job training, vocational rehabilitation and/or special education for sign language,
 - b) Massage therapy, rolfing and related services,
 - c) Inpatient rehabilitation facility services provided to an individual who is unconscious, comatose or otherwise incapable of conscious participation in the therapy services and/or unable to learn and/or remember what is taught including but not limited to coma stimulation programs and services,
 - d) Maintenance rehabilitation,
 - e) Speech therapy (unless it is due to stroke, surgery on vocal chords or neurological Injury). Speech therapy for functional purposes including but not limited to: stuttering, stammering and conditions of psychoneurotic origin, or for developmental speech delays, and
 - f) Treatment of delays in childhood speech development unless as a direct result of an Injury, surgery or result of a covered treatment.
33. Personal comfort items and expenses for patient convenience including but not limited to: care of family members while the covered individual is confined to a Hospital or other covered healthcare facility or in bed at home, including: guest meals, television, rental of DVDs or VCRs or devices to play them, telephone, personal hygiene items, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.
34. Expenses for an autopsy and any related expenses.
35. Expenses for preparing medical reports, bills or claim forms; mailing, shipping or handling expenses; and charges for broken/missed appointments, telephone calls and/or photocopying fees.
36. Expenses for educational services, supplies or equipment including, but not limited to computers, software, printers, books, tutoring, visual aides, auditory aides, speech aids, programs to assist with auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation or self-esteem, etc., even if they are required because of an Injury, Sickness or disability of a covered individual.
37. Expenses that exceed any Plan benefit limitation, Annual Maximum Plan benefits or overall Lifetime Maximum Plan benefits.
38. Any portion of the expenses for covered medical services or supplies determined by the Trustees to exceed the Allowable Charge as defined in the *Definitions* section on page 80.
39. Expenses for services or supplies for which a third party is required to pay because of the negligence or other tortious or wrongful act of that third party. See the provisions relating to subrogation, reimbursement, and third party liability on page 72 for an explanation of the circumstances under which the Plan will pay benefits until it is determined that the third party is required to pay for those services or supplies.

40. Expenses for any medical services, supplies, or drugs or medicines determined to be Experimental or Investigative as defined in the *Definitions* section on page 81.
41. Expenses for and related to non-emergency travel or transportation (including lodging, meals and related expenses) of a healthcare Provider, Participant or family member of a covered individual.
42. Expenses for any Physician or other healthcare Provider who did not directly provide or supervise medical services to the patient, even if the Physician or healthcare Provider was available to do so on a stand-by basis.
43. The following behavioral health exclusions:
 - a) Expenses for treatment and prevention of behavioral health disorders including Substance Abuse, except as provided under the applicable *Schedule of Benefits* and on page 4.
 - b) Expenses for residential care services for behavioral healthcare (except as provided in the applicable *Schedule of Benefits* on page 4).
 - c) Expenses for hypnosis, hypnotherapy and/or biofeedback, except as determined to be Medically Necessary and as provided by a licensed Physician.
 - d) Expenses for behavioral healthcare services related to: adoption counseling; attention deficit disorders (with or without hyperactivity) except when the services are for diagnosis and/or prescription of medication as prescribed by a Physician or other Behavioral Healthcare Practitioner; autism; court-ordered behavioral healthcare services; custody counseling; developmental disabilities; dyslexia; learning disorders, family planning counseling; genetic testing and counseling (see also the exclusion regarding genetic testing and counseling in Item 21 of this section), marriage, couples, and/or sex counseling; mental retardation; pregnancy counseling; transsexual counseling; and vocational disabilities.
44. The following custodial care expenses:
 - a) Expenses for care that is custodial in nature, regardless of where care is provided including without limitation: adult day care, child day care, services of a homemaker, or personal care, sitter/companion service.
 - b) Services required to be performed by Physicians or other covered Providers are **not** considered to be provided for custodial care services, and are covered if they are determined Medically Necessary. However, any services that can be learned to be performed or provided by a family member who is not a Physician or other covered Provider are **not covered**, even if they are Medically Necessary.
45. Pharmaceuticals requiring a prescription that have not been approved by the U.S. Food and Drug Administration (FDA) or are not approved by the FDA for the condition, dose, route and frequency for which they are prescribed (*i.e.* are used “off-label”) or are Experimental and/or Investigative as defined in the *Definitions* section on page 82.
46. Take-home drugs or medicines provided by a Hospital, Emergency Room, Outpatient Surgical Center, or other healthcare facility.
47. Expenses for and related to hearing examinations, the purchase, servicing, fitting and/or repair of hearing aid devices including: implantable hearing devices such as cochlear implants; and special education and associated costs in conjunction with sign language

48. Expenses related to cryostorage of umbilical cord blood or other tissue or organs.
49. Expenses for all medical or surgical services or procedures, including Prescription Drugs and the use of prophylactic surgery, when the services, procedures, prescription of drugs, or prophylactic surgery is prescribed or performed for the purpose of:
 - a) Avoiding the possibility or risk of a Sickness, disease, physical or mental disorder or condition based on family history and/or genetic test results; or
 - b) Treating the consequences of chromosomal abnormalities or genetically transmitted characteristics when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder.
50. Expenses for medical, surgical or Prescription Drug treatment related to transsexual (sex change) procedures including preparation for any complications resulting from these procedures.
51. Expenses for surgical correction of refractive errors and refractive keratoplasty procedures including, but not limited to, Radial Keratotomy (RK) and Automated Keratoplasty (ALK), or Laser In Situ Keratomileusis (LASIK).
52. Orthokeratology lenses for reshaping the cornea of the eye to improve vision.
53. Expenses for Durable Medical Equipment, except as provided on page 87.
54. Growth hormone, (except as Medically Necessary for Dependent Children).
55. Charges for the services of Non-Physician Providers, such as a Physician's Assistant, a Nurse Practitioner, a Nurse Midwife, a Certified/Registered Surgical Assistant, or an Assistant Surgeon, except that the services of a Certified Registered Nurse Anesthetist (CRNA) are covered as provided in Item 10 in the *Covered Expenses* section on page 28. The services of an Assistant Surgeon who is a Physician will be covered by the Plan.

How to File a Claim

Filing Claims Other than Major Medical Claims

Depending on the type of claim you have (death or dismemberment, medical, dental, vision, etc.), there are different requirements for filing a claim. This section provides more detail regarding how to file a claim.

If you need copies of your claim for your records, you should make them before submitting your claim. The Fund Office does not provide copying services. You are responsible for maintaining your own records. The following claim forms can be downloaded from the Fund's website at www.sm73funds.org

- Major Medical Claim Form
- Optical Claim Form
- Delta Dental Form
- Claim for Hearing Aid Benefit

Death Benefit or Accidental Death and Dismemberment Benefit Claims

To receive the Death Benefit or Accidental Death and Dismemberment Benefits, you or your Beneficiary must contact the Fund Office and follow the claim procedures in effect at the time of your claim. No claim form is required, but for:

- **Death Benefits**, your Beneficiary must submit a death certificate; and
- **Dismemberment Benefits**, you must submit a letter from your Doctor.

You must submit the required information within two years of the date of death or date of loss.

The Fund will notify you of its decision on your claim within 60 days of the date it receives your claim. This timeframe may be extended if the Fund Office needs additional information to process your claim. In that case, the Fund Office will notify you of the additional information that is needed and you will be given 45 days to provide the information. If you do not provide the information, the Fund Office will decide your claim on the basis of the information that has been provided and your claim may be denied.

If the claim is approved, the Fund Office will send a check in the applicable amount to you or to your Beneficiary.

Prescription Drug Benefits Claims

The Prescription Drug Benefits cover your short-term prescription needs through a Retail Pharmacy Network and long-term prescription needs through a Mail Order Prescription Drug Service.

Retail Pharmacy Network

The Retail Pharmacy Network is offered through CVS Caremark Prescription Service. If an acute medication (immediate treatment) has been prescribed for you, you should have the prescription filled at a participating network pharmacy. You must present the Prescription Drug card or other form of identification to the pharmacist and pay the applicable co-payment and deductible to the pharmacy. You will receive the prescription and no paperwork will be required. CVS Caremark will pay the balance of the cost of the prescription directly to the pharmacy.

If you do not use a participating network pharmacy, you are responsible to pay the entire cost of the prescription. You must complete a claim form and submit it to CVS Caremark in order to be reimbursed for covered Prescription Drugs obtained through a non-network pharmacy. Your reimbursement will be equal to the amount the Fund would have been charged for the prescription by the network pharmacy at the negotiated pharmacy rate, less the co-payment and deductible (if applicable).

The claim form should be sent to:

CVS Caremark Claims Dept.
P.O. Box 52196
Phoenix, Arizona 85072-2196

You may obtain a CVS Caremark Claim Form by contacting CVS Caremark at 1-800-776-1465, visiting their website at www.caremark.com or by contacting the Fund Office.

Mail Order Prescription Drug Service

The mail order Prescription Drug service is administered by CVS Caremark. If a maintenance medication (long-term treatment) has been prescribed for you, you should have the prescription filled through the mail order program. To order a prescription from the CVS Caremark Mail Order Prescription Drug Service, complete a CVS Caremark mail order form, enclose the prescription prepared by your Doctor, and send it to CVS Caremark. See page 48 for more information about the mail order prescription drug service administered by CVS Caremark.

Wellness Expense Benefit Claims

To receive the Wellness Expense Benefit, your Physician must submit a claim to Blue Cross Blue Shield of Illinois with a diagnosis code indicating the need for a general or routine physical exam and related expenses including certain diagnostic testing covered by the Plan.

You must also submit the following information to the Fund Office in order to obtain benefits under the Wellness Expense Benefit, if available:

- A completed Major Medical Claim Form, with Wellness Benefit indicated in Section #5,
- An itemized bill on which your Physician or Provider has used a diagnosis code that qualifies for reimbursement under the Fund,
- The matching Medicare Summary Notice (MSN, or Medicare explanation of benefits),
- The matching Explanation of Benefits (EOB) from the SMW+ Plan.

If Medicare denied the charge because it is a non-covered wellness claim, you do not need to submit the bill to SMW+. If Medicare has denied the charge, you must submit only the claim

form, itemized bill, and the matching Medicare Summary Notice (MSN, or Medicare explanation of benefits) to the Fund Office.

Dental Benefit Claims

If you go to a Delta Dental participating Dentist, the Dentist will submit a claim form directly to Delta Dental and you will only be responsible for any deductibles, copayments, and non-covered charges. If you go to a non-participating Dentist, you may be required to pay the Dentist his or her fees, and then file a claim with Delta Dental for reimbursement under the Dental Plan. You must include any information or proof necessary to process the claim.

Contact Delta Dental for the appropriate dental claim form. Complete the section of the claim form Member information.

You must complete a separate claim form for each member of your family who is filing for benefits – even if two people are filing for the same type of benefits. In addition, you must complete and file a new claim form each and every time a non-network claim is submitted. Be sure to give all information requested on the form and check all appropriate boxes. Delta Dental does not require their own claim form; the standard ADA (American Dental Association) claim form is acceptable.

Optical Expense Benefit Claims

To receive the Optical Expense Benefit, you must file a claim form with the Fund Office. Contact the Fund Office for the appropriate claim form. Complete the section of the claim form for Member information. You must complete and file a separate claim form for each member of your family who is filing for benefits – even if two people are filing for the same type of benefits. In addition, you must complete and file a new claim form each and every time a claim is submitted. Be sure to give all information requested on the form and check all appropriate boxes.

You must send an itemized bill with your claim form (or proof requested that is reasonably required to process such claims). You must pay the bill in full before the Fund will reimburse you for the Optical Expense Benefit. Have your optometrist complete the appropriate portion of the claim form and return the completed claim form to the Fund Office. Once approved, a check for the appropriate amount will be forwarded to you.

Hearing Aid Expense Benefit Claims

To receive the Hearing Aid Expense Benefit, you must file a claim form with the Fund Office. If you use a HearPO Provider, your Provider will file your claim for you. If you need a claim form, contact the Fund Office for the appropriate claim form. Complete the claim form section entitled *This Part of Form to be Completed by Member*.

You must complete and file a separate claim form for each member of your family who is filing for benefits – even if two people are filing for the same type of benefits. In addition, you must complete and file a new claim form each and every time a claim is submitted. Be sure to give all information requested on the form and check all appropriate boxes.

You must send an itemized bill with your claim or any information or proof requested that is reasonably required to process such claims. You must pay the bill in full before the Fund will reimburse you for the Hearing Aid Expense Benefit. Have your doctor or audiologist complete

the appropriate portion of the claim form and return the completed claim form to the Fund Office. Once approved, a check for the appropriate amount will be forwarded to you.

Workers' Compensation Claims Procedures

The Welfare Fund does not cover any claims for work-related Injuries or Sickneses. However, if the Industrial Commission initially determines that your Injury or Illness did not arise in the course of your employment, and you comply with the reimbursement agreement provisions of the Plan, which are outlined in the section beginning on page 72, the Plan may cover such claims, provided you do the following:

- You must promptly notify the Fund Office in the manner designated by the Fund Office that you have filed a workers' compensation claim.
- The Fund Office must verify that the benefit claims have been denied or disputed and are not being paid by the workers' compensation carrier pending resolution of the workers' compensation proceeding, and that such benefits are provided under the Fund. You must promptly inform the Plan Administrator or its designee in writing of all material developments with respect to your workers' compensation proceeding, and you must submit all benefit claims within six months of the decision in your workers' compensation case.
- The Fund will conditionally pay the covered benefit claims/expenses not paid by workers' compensation.
- The Fund's reimbursement provisions will control how the Plan provides coverage of any Plan benefits, rather than the terms of any workers' compensation settlement. You may contact the Fund Office or review the Reimbursement provisions on page 72.
- You must comply with all applicable reimbursement provisions outlined in the next section, including completion of the Fund's Reimbursement Agreement.

Claim Filing Period

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

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

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

Assignment of Benefits

If you use a network Provider or you complete the assignment of benefits section of a claim form and sign the claim to authorize the assignment of benefits, the claim will be processed and the check will be sent directly to your Provider as indicated in the assignment of benefits.

For dental claims, if the Dentist is a network Dentist, Delta Dental may pay the Dentist directly. If the Dentist is not participating in the network, Delta Dental may send payment to you, unless the

Delta Dental plan allows assignment of benefits in the state where you are receiving treatment, and you assign payment to the Dentist.

Comprehensive Major Medical Benefit Claims

For purposes of the Plan's claims and appeals procedures, medical claims include covered medical treatment from a covered Provider, wellness, hearing, optical services, prescription drug, and dental claims.

For medical treatment at a Hospital or through a Physician Provider, all claims should be submitted to Blue Cross Blue Shield of Illinois (including non-network Hospital or Provider claims). Present your card at the time of treatment, and the Provider will take care of submitting your claim for payment. You are responsible for ensuring that the claim is filed with the Plan.

Pre-Approval of Hospitalization or Inpatient Surgery – Blue Cross Blue Shield Medical Service Advisory (MSA)

If your Physician recommends elective or non-emergency hospitalization or elective Inpatient surgery, you must call the Blue Cross Blue Shield Medical Service Advisory (MSA) at least one business day before you go into the Hospital. If it is an emergency admission, you, your doctor, the Hospital or a family member must call the Blue Cross Blue Shield MSA within two business days of the date of admission. ***If you do not call the Blue Cross Blue Shield MSA within these periods of time, you will have to pay an additional copayment of \$250 before the Fund will pay any benefits. The telephone number for the Blue Cross Blue Shield MSA is 1-800-255-5192.*** For maternity admissions, you are encouraged, but not required, to contact the Blue Cross Blue Shield MSA before you are admitted into the Hospital.

There are 4 types of medical claims under the Plan: pre-service, urgent, concurrent and post-service medical claims. The Fund's procedures for handling each type of claim are outlined here.

Pre-Approval of Certain Medical Benefits Through the Fund Office

If your Physician prescribes contraceptives for a Medically Necessary reason, other than contraception, you must contact the Fund Office for prior approval. In addition, if your Physician prescribes physical, occupational, or speech therapy, you must contact the Fund Office for prior approval of your treatment plan, as described on page 28. The Fund Office may submit your claim to its Contracted Medical Claim Review Provider to determine whether your claim will be covered by the Plan.

If your Physician prescribes the use of Medically Necessary Durable Medical Equipment, you must contact the Fund Office for prior approval of the equipment, as provided on page 29.

Pre-Service Medical Claims

You are required to get Plan approval in advance of elective surgery, hospitalization, and certain other benefits. The Plan will make a decision on your pre-service claim and notify you of the decision within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after receiving your claim. If the Plan requires an extension of time due to matters beyond the control of the Plan, the Plan will notify you of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 15-day period. A decision will be made within 15 days of the time the Plan notifies you of the delay.

If the Plan needs additional information from you to make its decision, you will be notified as to what information must be submitted. You will have at least 45 days to submit the additional information. Once the Plan receives the information from you, you will be notified of the Plan's decision on the claim within 15 days.

Urgent Care Medical Claims

Urgent care claims are claims for medical care or treatment that would:

- Seriously jeopardize your life or health if normal pre-service standards were applied, or
- Subject you to severe pain that cannot be adequately managed without the care or treatment for which approval is sought, in the opinion of a Physician with knowledge of your condition.

If your claim involves urgent care, the Plan will make a decision on your claim and notify you of the decision as soon as possible, taking into account your medical needs, but not later than 72 hours after the Plan receives your claim.

If you do not provide sufficient information to determine whether or to what extent benefits are covered or payable for urgent care, the Fund Administrator or its designee will notify you as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. You must provide the specified information within 48 hours. If you do not provide the information, your claim will be denied.

Concurrent Care Medical Claims

Concurrent claims involve a reconsideration of services you are currently receiving. In some cases, the Plan may approve your claim for a certain number of visits or for a certain length of time. For example, the Plan may approve a Hospital stay for five days for treatment of a medical condition.

The Plan may decide to reduce or terminate the number of visits or length of time that was previously approved. If such a decision is made, the Plan will inform you of the decision sufficiently in advance of the reduction or termination so that you can request and receive a review of the decision before it takes effect.

If you request an extension of the number of visits or length of time at least two hours before the expiration of the approved limit and your request involves urgent care, the Plan will make a decision on your request and notify you of the decision within 24 hours. All other requests for extensions will be handled as Pre-Service Claims.

Post-Service Medical Claims

For claims you submit after you have received the services, the Plan will make a decision on your claim and notify you of the decision within 30 days of receiving your post-service claim. If the Plan requires an extension of time due to matters beyond the control of the Plan, the Plan will notify you of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 30-day period. A decision will be made within 15 days of the time the Plan notifies you of the delay.

If the Plan needs additional information from you to make its decision, you will be notified as to what information must be submitted. You will have at least 45 days to submit the additional

information. Once the Plan receives the information from you, you will be notified of the Plan's decision on the claim within 15 days.

If Your Claim is Denied

If your claim is denied in whole or in part, you will receive notice of the denial of your claim within the appropriate time frame that provides the following information:

- The specific reason or reasons your claim was denied,
- A reference to the specific Plan provisions on which the denial was based,
- A copy of an internal rule, protocol or guideline which was relied on in making the denial,
- If the determination was based on Medical Necessity, experimental or investigational exclusion, or similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination, applying the terms to the claim or a statement that the explanation is available upon request at no charge,
- A description of any additional information you need to submit to support your claim,
- An explanation of why the additional information is needed,
- An explanation of the Plan's claim appeal procedures and applicable time limits, and
- A statement of your right to bring a civil action under ERISA following an adverse benefit determination.

If you do not receive the notice within such time period and there has been no settlement on your claim, you should write to the Fund Office for information.

Appealing the Denial of Your Claim

If your claim is denied, you are entitled to a full and fair review of your claim. In addition to covered medical treatment from a covered Provider, claims include wellness, hearing, optical services, prescription drug and dental claims.

For Medical claims, you or your authorized representative must submit your written appeal within 180 days of the denial of your claim. If your claim involves an urgent care medical claim, you may make your request for review orally.

You can appeal your claim if it is denied. You must file your written appeal within 180 days for Medical claims or within 60 days for Death Benefit and Accidental Death and Dismemberment claims. Urgent care claims may be made verbally.

In making your appeal, you or your authorized representative will be entitled to submit additional proof that you are entitled to benefits and examine any document related to your claim that is in the possession of the Fund Office. You will also be entitled to review all relevant information (free of charge) upon reasonable request to the Trustees. A document, record or other information is relevant if:

- It was relied upon by the Plan in making the decision,
- It was submitted, considered or generated in the course of making the decision, regardless of whether it was relied upon in making the decision, or
- It demonstrates compliance with the claims processing requirements.

The decision on your appeal will be made as soon as possible and no later than within:

- 60 days of your Death Benefit or Accidental Death and Dismemberment claim,
- 60 days of receiving your written appeal for post-service claims,
- 30 days of receiving your written appeal for pre-service claims, and
- 72 hours for urgent care claims.

These are the Fund's deadlines for making a decision on your appeal.

The Trustees have designated a Benefits Appeal Committee comprised of two Employer Trustees and two Union Trustees to review and decide on all claim appeals on a monthly basis. If the members of the Benefits Appeal Committee agree on the decision, then their decision is a final and binding decision. If the Benefits Appeal Committee deadlocks on a claim appeal, then the appeal is not approved and the prior decision by the Fund Office is a final and binding decision.

The written notice of the decision on review will include:

- The specific reason or reasons your claim was denied,
- A reference to the specific Plan provisions on which the denial was based,
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim upon request and free of charge,
- A statement of your right to bring a civil action under ERISA following an adverse benefit determination on review, and
- A statement about alternative ways to appeal the decision and referral to the Department of Labor or your state's regulatory agency.

The Trustees have discretionary authority to determine all benefit claim appeals and to interpret the documents governing the Plan. The determination rendered by the Trustees will be binding on all parties. The Trustees' decision in your appeal will be given judicial deference in any later court action or administrative proceeding to the extent that it does not constitute an abuse of discretion, and is not arbitrary or capricious. You must follow the Plan's appeal procedures before you are permitted to bring any court action against the Plan.

Limitation on Legal Actions

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

You may not bring a legal action or administrative proceeding until you have exhausted the Plan's claims and appeals procedures.

Payment of Benefits

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

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

If you assign benefits to a Provider, the Plan will make payments in accordance with the assignment. Unless the Trustees consent, no assignment of any present or future right, interest, or benefit under this Plan will bind the Trustees.

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

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

Misrepresentation or Falsification of Claim and Wrongfully Paid Benefits

If the Plan erroneously pays benefits because of false information or misrepresentations entered on your enrollment form, claim form or required documentation, or due to a mistake, then the Plan will be entitled to:

- A refund from you or your healthcare Provider of the difference between the amount paid by the Plan for those expenses and the amount of Plan benefits that should have been paid by the Plan for those expenses based on the actual facts, or
- An offset of future benefits to recover such expenses, and
- A recovery from you of the Plan's attorney's fees, costs and expenses incurred in recovering monies that were wrongfully paid because of such misrepresentation or falsification.

Coordination of Benefits

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

Under the Coordination of Benefits (COB) provision for benefits other than dental services, if you or any of your Dependents are also covered under any other group plan, the total payments you will receive from all such programs combined will not amount to more than 100% of Allowable Charges. Allowable Charges are any Medically Necessary and Allowable Charges for medical services, treatment or supplies covered by one of the plans under which you or your Dependent is covered.

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

Under the Coordination of Benefits (COB) provision for benefits that are dental services, if you or any of your Dependents are also covered under any other group plan, the total payments you will receive from all such programs combined will not amount to more than 100% of allowable expenses. If the allowable expense used by the Plan is lower than the amount used by the primary plan as the allowable expense, then the Plan will use the allowable expense amount used by the primary plan, which may be less than the actual charge. When the Plan pays dental benefits as the secondary payer, it deducts the primary payer's payment from the total approved fee, and then it pays the lesser of the balance due or what it would have paid if the Plan had been the primary payer. When the Plan is the secondary payer, it determines payment on the total dollar amount of the approved fee for the dental claim, and not on a line by line basis. The Plan will pay only for dental care expenses that are covered by this Plan.

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

Determining Which Plan Pays First

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

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

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

- When another plan does not have a Coordination of Benefits provision (COB provision), that plan must determine benefits first.
- When another plan does have a COB provision, the first of the following rules that applies governs:
 - If a plan covers the claimant as an active Employee, then that plan will pay its benefits first.
 - For an Eligible Dependent child whose parents are not divorced or separated, the plan of the parent whose birthday (month and day) is earlier in the calendar year will pay first. If both parents' birthdays are the same day, the last rule will apply.
 - For an Eligible Dependent child whose parents are divorced or separated, the following rules apply:
 - A plan that covers a child as a Dependent of a parent who by court decree must provide health coverage will pay first.
 - When there is no court decree that requires a parent to provide health coverage for a Dependent child, the following rules will apply:
 - ◆ When the parent who has custody of the child has not married, that parent's plan will pay first and the non-custodial parent's plan will pay second.
 - ◆ When the parent who has custody of the child has remarried, benefits will be determined by that parent's plan first, by the stepparent's plan second, and by the non-custodial parent's plan third.
 - If none of the above rules apply, the plan that has covered the claimant for the longest period of time will pay its benefits first, except:
 - When one plan covers the claimant as a laid-off or retired Employee (or a Dependent of such an Employee), and the other plan includes a COB rule for laid-off or retired Employees, the plan that covers the claimant as other than a laid-off or retired Employee (or a Dependent of such an Employee) will pay first,
 - If both plans cover the claimant as a laid-off or a retired Employee (or a Dependent of such Employee) the plan that covered the Employee for the longest period of time will pay first.

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

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

If part of a plan coordinates benefits and a part does not, each part will be treated like a separate plan. The Plan will always pay primary to Medicaid.

Notwithstanding any provision to the contrary, if an Eligible Dependent is covered by another group health plan that reduces or eliminates its benefits when a Dependent is covered by another group health plan, or if the other group health plan has COB provisions that differ from those of this Plan, this Plan will only pay the amount of benefits that would be payable if the other group health plan had the same coordination of benefit provisions as this Plan.

Information Required for Coordination of Benefits

For the purposes of Coordination of Benefits, the Fund Office:

1. May release to or obtain from any other plan or other organization or person any claim information, and any person claiming benefits under the Fund must furnish any information that the Fund may require to coordinate benefits, in accordance with the federal law governing privacy and security of your medical records,
2. Has the right, if an overpayment is made, to recover such overpayment from any other person or any other plan or organization, and
3. Has the right to pay to any other plan or organization an amount it will determine to be warranted, if payments that should have been made by the Fund have been made by such organization.

WARNING

If you or your Dependents file a claim with the Welfare Fund Office and fail to disclose relevant information concerning your coverage by another plan or other matters relating to coordination of benefits, the Welfare Fund has the right to recover any and all overpayments directly from you, your Dependents, your insurance company or any other person or organization. The Fund also has the right to withhold benefits from you or your Dependents until such amounts are recouped.

How Medicare Affects Medical Benefits Under the Plan

About Medicare

Medicare is a four-part program. The first part is officially called “Hospital Insurance Benefits for the Aged and Disabled” and this part is commonly referred to as Part A of Medicare. The second part is officially called “Supplementary Medical Insurance Benefits for the Aged and Disabled” and this part is commonly referred to as Part B of Medicare. The third part is Medicare Advantage or Medicare Part C and generally involves coverage under one of the Medicare HMO (Health Maintenance Organization) offerings for Participants who live in a geographic area served by a Medicare HMO and who choose to be covered by a Medicare HMO. Medicare Part D provides Prescription Drug coverage. Part A of Medicare primarily covers Hospital benefits, although other benefits are also provided. Part B of Medicare primarily covers Physician’s services, although it, too, covers a number of other items and services. Part C covers both Hospital and Physician services. Part D covers Prescription Drug expenses.

Typically a person becomes eligible for Medicare upon reaching age 65. Under certain circumstances a person may become eligible for Medicare before age 65 if the person is a disabled worker, disabled widow, or Dependent widower or has chronic renal disease.

When you reach age 65, you are eligible to apply for all parts of Medicare coverage. Part A of Medicare is ordinarily free, and premiums are required for the other Parts of Medicare. If you are not yet receiving Social Security benefits, you must pay any required premium to the Social Security Administration. If you are receiving Social Security Benefits, you will have the premium deducted from your monthly Social Security benefit check.

Coordination of Your Plan Benefits with Medicare

The Plan coordinates benefits with Medicare.

In general, Medicare is the primary plan responsible for paying benefits for Plan participants who are enrolled in Medicare Parts A and B, or Part C. Additional benefits that are not covered by Medicare are offered by this Plan to eligible Retirees and their Eligible Dependents. For those additional benefits, this Plan is primary.

If you are enrolled in Medicare Part A and Part B, you may be eligible to participate in the Sheet Metal Workers’ Local 73 Supplemental Wraparound Insurance (SMW+).

If you are covered by this Plan as a Retiree and you are eligible to enroll in Medicare Part D, you are not required to enroll in Medicare Part D. The Plan will pay your Prescription Drug Benefits, without taking eligibility for Medicare Part D into account. However, if you are eligible for, and enroll in Medicare Part D, you will lose your Prescription Drug benefits provided by the Plan.

Reimbursement Policies and Procedures

If the Welfare Fund pays benefits to or for you, your Dependent, your estate or your Dependent's estate as a result of an accident, Injury, or Sickness for which any third party is or may be liable, the Fund has a right to be reimbursed from any settlement, judgment, insurance proceeds, no-fault automobile insurance payments, or other recovery for any and all benefits paid in connection with such Injury and Sickness up to the amount of recovery.

In addition, the Fund will have a first equitable lien and constructive trust upon any such recovery in the amount of all benefits paid up to the amount of your recovery, regardless of how the recovery is allocated or structured. You must hold any such recovery in constructive trust for the benefit of the Fund. The Fund's right of reimbursement is from the first dollar you receive. The enforcement of this right does not require that you be made whole or otherwise receive your full claim from the third party, unless the Fund agrees in writing to a reduction of its claim.

You, your Dependent or estate must sign the Fund's written Reimbursement Agreement Form acknowledging the Fund's rights under this provision. The Fund may withhold benefits until such agreement is signed. If the Fund pays a claim in the absence of a Reimbursement Agreement, or pays a claim in error, that payment will not waive, compromise, diminish, release, or prejudice any right the Plan has to reimbursement or a lien.

You, your Dependent or estate must immediately inform the Fund in writing of any legal action or any recovery that arises subsequent to the payment of benefits by the Fund. You, your Dependent or estate must cooperate fully with the Fund in connection with the exercise of its rights under this provision and must do nothing to prejudice such rights.

You must avoid doing anything that would prejudice the Plan's right of reimbursement and repayment. In the event there is a claim against a third party, you must promptly advise the Fund.

The Common Fund Doctrine will not apply to any recovery, and the Fund will not pay fees or costs incurred in connection with any sum recovered unless the Fund has agreed in writing to pay a portion of those fees or costs. The amount recoverable by the Fund includes any and all amounts paid by the Plan in relation to your Sickness or Injury, all administrative fees and expenses related to the claim (such as PPO access fees) and the Fund's costs and reasonable attorneys' fees (even for appeals) regardless of the amount of your actual recovery. The Plan's reimbursement and lien rights apply, without regard to state law limitations on liens against workers' compensation recoveries.

The Fund may, at its option, initiate legal action to secure and protect its rights under this provision.

In the event that reimbursement is not made as provided above, the Fund has the right to withhold any future benefits that you, your Dependent or estate may be entitled to receive until the Fund has been reimbursed. In the event that you, your Dependent or estate fails to timely inform the Fund of any recovery, the Fund will have a right of reimbursement from you, your Dependent or estate for any and all benefits paid and for costs of suit, including payment of reasonable attorney fees, regardless of the amount of the actual recovery. The Fund Office may also suspend your benefits after giving you a 30-day notice of suspension, if the Fund Office learns that you have received a recovery without making reimbursement to the Fund and if you are not engaged in good faith negotiations to settle the Fund's right to reimbursement.

Benefits to Which Reimbursement Applies

The Plan's Reimbursement provisions apply to the following benefits paid by the Plan: medical, dental, vision, prescription drug, hearing aid, and any other benefits paid by the Sheet Metal Workers' Local 73 Welfare Fund under any plan of benefits provided by the Fund. The Plan's Reimbursement provisions do not apply to Death Benefits or Accidental Death and Dismemberment Benefits provided by the Plan.

Situations Where Reimbursement Provisions May Apply

The Plan has the right of reimbursement for benefits that it pays as a result of an Injury, accident or Sickness for which any third party may be liable. This can include auto accidents, workers' compensation injuries, personal injuries, medical malpractice injuries, injuries from fights or beatings, poisonings or toxic injuries, or a case of slip and fall.

Reimbursement Procedures

The Board of Trustees has established reimbursement procedures for the Welfare Fund that they may change from time to time. The Fund Office will follow the reimbursement procedures. The Board of Trustees of the Welfare Fund has delegated full discretionary authority to the Benefits Appeals Committee of the Board of Trustees to collect and settle Reimbursement claims.

If you sign a Reimbursement Agreement, the Fund may reduce its share of the recovery for its proportionate share of attorneys' fees and its share of your out-of-pocket expenses. The Trustees or Appeals Committee have the discretion to settle reimbursement claims or liens. Other guidelines apply to the recovery available by the Fund. Contact the Fund Office for more details.

Refusal to Cooperate in Reimbursement Claims

The Fund Office may suspend benefit payments for your claims related to third-party Injury or illness until you return a signed Reimbursement Agreement to the Fund Office. The Fund Office may also suspend benefits or withhold future benefit payments if you refuse to provide information to the Fund Office or otherwise refuse to cooperate with the Fund Office.

The Fund Office may suspend all Welfare Benefit payments or withhold future benefit payments, regardless of the nature or source, if you receive a recovery and you either fail to report that recovery to the Fund Office, refuse to reimburse the Fund Office, or reject a settlement in accordance with the Plan's Reimbursement guidelines. Benefits should recommence after the total amount of payments withheld equals the amount of recovery due the Fund under the Fund's Reimbursement policies and procedures.

Important Information About the Plan

The following information is provided to help a member identify this Fund and the people who are involved in its operation.

Name of Plan. This Plan is known as the Sheet Metal Workers' Local 73 Welfare Fund Plan for Retired Members.

Board of Trustees. A Board of Trustees is responsible for the operation of this Fund. The Board of Trustees consists of equal representation of Employer and Union representatives, selected by the Employers and the Union that have entered into collective bargaining agreements that relate to this Fund. If you wish to contact the Board of Trustees, you may use the following address and phone number:

Sheet Metal Workers' Local 73 Welfare Fund
4530 Roosevelt Road
Hillside, Illinois 60162
1-708-449-7373

As of January 1, 2010, the Trustees of this Fund are:

Union Trustees	Employer Trustees
Mr. Rocco Terranova Sheet Metal Workers' Local 73 Welfare Fund 4550 Roosevelt Road Hillside, Illinois 60162	Mr. John Delano P.O. Box 7073 Evanston, Illinois 60204
Mr. Robert Schneider Sheet Metal Workers' Local 73 Welfare Fund 4550 Roosevelt Road Hillside, Illinois 60162	Mr. John P. Harmon, Sr. Builders Heating, Inc. 4633 West 138 th Street Crestwood, Illinois 60445
Mr. Michael A. Vittorio Sheet Metal Workers' Local 73 Welfare Fund 4550 Roosevelt Road Hillside, Illinois 60162	Mr. Jack Baer Air Comfort Corporation 2550 Braga Drive Broadview, Illinois 60153

Plan Sponsor and Administrator. The Board of Trustees is both the Plan Sponsor and the Plan Administrator. This means that the Board of Trustees is responsible for the operation and administration of the Plan. The Plan Administrator has broad discretion to determine eligibility for benefits and to interpret the language of the Plan. The Plan Administrator's decisions should receive judicial deference to the extent that they do not constitute an abuse of discretion. The Board has delegated the day-to-day administrative responsibilities to the Fund Administrator, Joseph Ohm, who can be contacted at the Fund Office.

Identification Numbers. The number assigned to the Board of Trustees by the Internal Revenue Service is 36-2145881. The number assigned to this Fund by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501.

Agent for Service of Legal Process. John F. Gregorio, Esq. of Gregorio and Associates, Two N. LaSalle Street, Suite 1650, Chicago, Illinois 60602 is the Fund's agent for service for legal process. Accordingly, if legal disputes involving the Fund arise, any legal documents may be served upon him at his address or any of the Trustees at the Fund Office address.

Source of Contributions. Contributions to the Fund are made by Employers in accordance with their collective bargaining agreement with Sheet Metal Workers' International Association Local 73 of Chicago, Cook and Lake Counties, Illinois AFL-CIO or participation agreement. However, in specific situations, self-payments are required to be made pursuant to the provisions of the Fund.

The Fund Office will provide you, upon written request, information as to whether your Employer is participating in this Plan and the Employer's address.

Trust Fund. All assets are held in trust by the Board of Trustees for the purpose of providing benefits to you and your Dependents as Plan Participants and defraying reasonable administrative expenses. The Fund's assets and reserves are presently invested by the Board of Trustees.

Benefit Administration. Prescription Drug Benefits are administered by CVS Caremark. Dental Benefits are administered by Delta Dental. Medical benefits are administered by Blue Cross Blue Shield of Illinois. All benefits are provided on a self-funded basis directly from the Fund.

Plan Year. The records of the Plan are kept separately for each Plan Year. The Plan Year begins July 1 and ends on June 30.

Type of Plan. This Plan is maintained for the purpose of providing health, prescription drug, dental, wellness, hearing, vision, death and accidental death and dismemberment benefits in the event of Sickness, accident or death. The Plan benefits are shown in the applicable *Schedule of Benefits* on page 3 or 6 of this booklet.

Collective Bargaining Agreement. The Fund is maintained in accordance with a collective bargaining agreement between the contributing Employers and Sheet Metal Workers' International Association Local 73 of Chicago, Cook and Lake Counties, Illinois AFL-CIO. You may obtain a copy of the agreement by written request to the Board of Trustees. A reasonable charge may be imposed for the copy. In addition, a copy of the agreement may be examined without charge at the Fund Office or at the principal place of business of your Employer.

No Employment Guarantee. Your coverage by the Fund does not constitute a guarantee of your continued employment.

Plan Documents. This booklet constitutes a summary of your benefits known as the Summary Plan Description. This edition of your Summary Plan Description replaces any prior Summary Plan Description booklets and other summaries of the provisions of the Plan.

The Trustees have written this summary in clear, understandable and informal language. However, if you have any questions about this booklet, you should call the Fund Office for information about how your benefit plan works.

Other important documents are the Plan Document for the Sheet Metal Workers' Local 73 Welfare Fund Plan for Retired Members, the Agreement and Declaration of Trust and the

collective bargaining agreements. If there is any conflict between the provisions in this Summary Plan Description booklet and the Plan Document, the terms of the Plan Document govern.

Amendment or Termination of the Plan. While the Trustees fully intend to continue the Plan, they reserve the right and they have the broad discretion to alter or discontinue the Plan. The provisions of the Plan may be amended from time to time in accordance with the Trust Agreement. Amendments may include increases, modifications, reductions or the elimination, in whole or in part, of certain benefits. The Board of Trustees has the right to initiate, increase and/or decrease self-payments.

The Plan may be terminated under circumstances allowed by ERISA and the terms of the governing Trust Agreement. In addition, the Trustees reserve the right to initiate, increase and/or decrease self-payments for Plan coverage. If the Trustees amend or terminate the Plan, they will notify you in writing of the changes that are made to your coverage.

If the Plan is terminated, benefits for covered expenses incurred before the termination date fixed by the Trustees will be paid to eligible Participants, as long as the Plan's assets are more than the Plan's liabilities. If there are any excess assets remaining after the payment of all Plan liabilities, those excess assets will be used for purposes determined by the Trustees in accordance with the provisions of the Trust Agreement.

The Trustees, as Plan Administrator, have broad discretion to amend or terminate the Plan. If the decisions of the Plan Administrator are challenged in court, it is the intention of the Fund that the Plan Administrator's decisions be accorded judicial deference to the extent that they do not constitute an abuse of discretion.

No Vested Right to Plan Benefits. Your coverage by the Plan does not confer any right to continue benefits. The welfare benefits provided by the Plan are not vested benefits.

Statement of Rights Under the Employee Retirement Income Security Act (ERISA)

As a Participant in the Sheet Metal Workers' International Association Local Union No. 73 Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all Plan Participants are entitled to the following rights.

Receive Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Fund Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan. These include insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request to the Fund Administrator, copies of documents governing the operation of the Plan. These include insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Fund Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Fund Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You also have the right to:

- Continue healthcare coverage for yourself, spouse, or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.
- Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when:
 - You lose coverage under the Plan,
 - You become entitled to elect COBRA continuation coverage, or
 - Your COBRA continuation coverage ceases.

You must request the certificate of creditable coverage before losing coverage or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit plan. The people who operate your

Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Fund Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Fund Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

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

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (EBSA). For single copies of publications, contact the EBSA Brochure Request Line at 866-444-3272 or contact the EBSA field office nearest you.

You may also find answers to your Plan questions at the website of the EBSA at <http://www.dol.gov/ebsa/>. A list of EBSA Field Offices is located at <http://www.dol.gov/ebsa/aboutebsa>.

Your Privacy Rights Under the Plan

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health plans protect the confidentiality and electronic security of your protected health information (PHI). You may find a complete description of your rights under HIPAA in the Plan's Privacy Notice that describes the Plan's privacy policies and procedures and outlines your rights under the privacy rules and regulations.

The Plan will distribute its Privacy Notice or a reminder that the notice is available from the Fund Office periodically, as required by the privacy rules, and when substantial changes are made in the Plan's privacy policies and procedures.

This Plan and the Plan Sponsor will not use or further disclose your protected health information except as necessary for treatment, payment, health plan operations and Plan administration or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose your protected health information for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor.

<p>Protected Health Information (PHI) includes all information related to your past, present or future physical or mental health condition or payment for healthcare. PHI also includes information maintained by the Plan in oral, written or electronic form.</p>

The Plan also hires professionals and other companies to assist it in providing healthcare benefits. The Plan has required these entities, called "Business Associates" to observe HIPAA's privacy and security rules. In some cases, you may receive a separate notice from one of the Plan's Business Associates. It will describe your rights with respect to benefits provided by that company.

Your rights under HIPAA with respect to your protected health information include the right to:

1. See and copy your health information;
2. Receive an accounting of certain disclosures of your health information;
3. Amend your health information under certain circumstances; and
4. File a complaint with the Plan or with the Secretary of Health and Human Services if you believe your rights under HIPAA have been violated.

If you need a copy of the Privacy Notice, please contact the Fund Office.

Definitions

Allowable Charge means:

1. For a network provider, the Allowable Charge is the negotiated fee/rate set forth in the agreement with the participating health network, provider, facility, or organization and the Plan.
2. For an out-of-network provider, the Allowable Charge means the amount as determined by the Board of Trustees that the Plan will pay for a particular service or supply. For these purposes, the Board of Trustees has adopted a schedule based on 120% for Physician charges and 150% for facility charges of the Medicare allowable amount for out-of-network claims. Under no circumstances will the Plan pay an Allowable Charge for out-of-network services or supplies that are determined by any provider, facility, or other person or organization other than the Board of Trustees.

Ambulatory Surgical Facility means a facility (other than a Hospital), that:

1. Has the primary function of providing surgical procedures on an ambulatory basis, and
2. Is duly licensed by the appropriate state and local authority to provide such services and, if the facility is an in-network facility, it is approved by Blue Cross Blue Shield of Illinois.

Behavioral Health Practitioner means a psychiatrist, mental health counselor, Substance Abuse counselor or social worker with a masters degree or higher. The Provider must be legally licensed or authorized to practice or provide service, care or treatment for such conditions under state law, and act within the scope of that license.

Beneficiary means a person you designate to receive your life insurance benefits.

Child has the meaning provided in the definition of Dependent, as defined in the *Eligibility* section on page 11.

Contracted Medical Claim Review Providers mean the third-party reviewers that provide medical review of claims for services that require pre-approval that is arranged through the Fund Office. Such reviewers determine whether services and the proposed duration of services is Medically Necessary.

Covered Employment means work for which a contributing Employer is required to make contributions to the Welfare Fund on behalf of Employees pursuant to the terms of a collective bargaining agreement with Sheet Metal Workers' Local Union No. 73 or participation agreement with the Fund.

Dental Hygienist means a person who is duly licensed as a Dental Hygienist currently practicing within the scope of his or her license, performing services under the direction of a licensed Dentist, and must not be the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Dental Treatment Plan is a Dentist's report, on a form satisfactory to the Plan that:

1. Itemizes the dental services recommended by the Dentist for the necessary and customary dental care of an eligible person,
2. Shows the charge for each dental service, and
3. Is accompanied by appropriate diagnostic materials as required by the Plan.

Dentist is a duly licensed Dentist (D.D.S. or D.D.M.) currently practicing within the scope of his or her license and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Diagnostic Services means tests rendered for the diagnosis of symptoms to evaluate or determine the progress of a condition, disease or Injury. Such tests include but are not limited to x-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests and electromyograms.

Durable Medical Equipment means equipment that meets all of the following requirements (see the list in Appendix A):

1. Can withstand repeated use (*i.e.*, could normally be rented and used by successive patients),
2. Is primarily and customarily used to serve a medical purpose,
3. Generally is not useful to a person in the absence of Sickness or Injury,
4. Is appropriate for use in the home, and
5. Is used solely for the care and treatment of the patient.

The Trustees have the authority and discretion to determine what constitutes Durable Medical Equipment and covered supplies for items not listed in Appendix A, and when to rent, lease or purchase the equipment.

Eligible Dependent has the meaning provided in the *Eligibility for Non-Medicare Eligible Retirees* section on page 11.

Emergency means the sudden and unexpected onset of a traumatic bodily Injury or Sickness with severe symptoms:

1. That requires immediate diagnosis or treatment to prevent serious physical impairment or death,
2. For which you or your Dependent seeks medical care immediately and in no event more than 24 hours after the onset of the symptoms, and
3. In the event of a Mental or Nervous Disorder, or Behavioral Health Disorder, the lack of the treatment could reasonably be expected to result in the self-harm or harm to others by the patient.

Employee means an individual, employed by an Employer, on whose behalf the Employer, pursuant to a collective bargaining agreement with the Union or participation agreement with the Fund, is or has been required to make contributions to the Trust Fund.

Employee also means a full-time teacher in the Local 73 Sheet Metal Workers' Apprenticeship Program and the Eligible Dependents of that teacher, provided the appropriate contributions are made to the Plan on behalf of the Employee.

Sole Proprietors, or partners in a partnership or similar business entity required to make Employer Contributions to the Plan are not considered Employees under the Plan, unless they meet the definition of Employee in the prior two paragraphs.

Employer means an Employer that has or may hereafter have a collective bargaining agreement in effect with the Union requiring periodic payments to the Sheet Metal Workers' Local 73 Welfare Fund for Active Members for the purpose of providing and maintaining group insurance for the benefit of its Employees.

The term Employer also includes any other Employer that, with the consent of the Trustees, makes payments or contributions to the Welfare Fund and adopts and agrees to be bound by the terms and provisions of the Sheet Metal Workers' Local 73 Welfare Fund Trust Agreement and any amendments and modifications thereof.

Experimental or Investigative means drugs, services, supplies and procedures that require approval by an agency of the U.S. Government that has not yet been received. Experimental treatments, services and supplies are also those that have been principally confined to laboratory or research settings or have progressed to limited human application but lack wide recognition as proven and effective in clinical medicine. The Trustees have the discretionary authority to determine whether a treatment, service or supply is Experimental or Investigative. The fact that a Physician has prescribed, ordered, recommended or approved the treatment, service or supply does not in itself make it eligible for payment.

Hospital public or private facility or institution, licensed and operating according to law that:

1. Is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), is approved by Medicare as a Hospital, and provides care and treatment of Physicians and Nurses on a 24-hour basis for Sickness or Injury through the medical, surgical, and diagnostic facilities on its premises;
2. May include facilities for treatment of Mental and Nervous Disorders or Behavioral Health Disorders that are licensed and operated according to law;
3. May include facilities for acute care, sub-acute care, and specialty Hospitals; and
4. May include any portion of a Hospital used as an Ambulatory Surgical Facility, Birth (or Birthing) Center, Hospice, Skilled Nursing Facility, or Subacute Care Facility.

A residential treatment facility or place for rest, custodial care, or place for care of the aged will not be regarded as a Hospital for any purpose related to this Plan.

Injury means a bodily Injury that requires treatment by a Physician, and that results in a loss that is independent of Sickness and other causes.

Inpatient means that you are a registered bed patient and are treated as such in a Hospital or Skilled Nursing Facility.

Medically Necessary means that there is a proven need for treatment intervention to improve or preserve the health of the patient. To be considered Medically Necessary, the service, supply or treatment must:

1. Be ordered by a Physician for diagnosis or treatment.
2. Be consistent with the diagnosis or treatment.
3. Be essential for the diagnosis or treatment of the Injury or Sickness for which it is prescribed or performed.
4. Meet generally accepted standards of medical practice.
5. Not be of a research, experimental, or educational nature.
6. Not involve repeated tests.

THE FACT THAT A PHYSICIAN MAY PRESCRIBE, ORDER, RECOMMEND OR APPROVE A TREATMENT, SERVICE OR SUPPLY DOES NOT, OF ITSELF, MAKE THE TREATMENT, SERVICE OR SUPPLY MEDICALLY NECESSARY OR MAKE THE EXPENSE A COVERED CHARGE.

Mental or Nervous Disorder or Behavioral Health Disorder means a neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind, as defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or as identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Non-Physician Providers means Providers whose services are excluded from Plan coverage. These Providers include, but are not limited to the following:

1. **Physician Assistant:** A person legally licensed as a Physician Assistant, who acts within the scope of his or her license, who is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient, and acts under the supervision of a Physician to: examine patients; establish medical diagnoses; order, perform and interpret laboratory, radiographic and other diagnostic tests; identify, develop, implement and evaluate a plan of patient care; prescribe and dispense medication within the limits of the person's license; refer to and consult with the supervising Physician; and bill and be paid in the Physician Assistant's own name under the laws of the state or jurisdiction where the services are rendered.
2. **Nurse Assistant:** A person legally licensed as a Certified Nurse Midwife or licensed Midwife, Nurse Practitioner, Licensed Vocational Nurse, Psychiatric Mental Health Nurse, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.
3. **Nurse Practitioner:** A person legally licensed as a Nurse Practitioner, Family Nurse Practitioner or Registered Nurse Practitioner who acts within the scope of the Nurse Practitioner's license, is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient, and in collaboration with a Physician: examines patients; establishes medical diagnoses: orders, performs and interprets laboratory, radiographic and other diagnostic tests; identifies, develops, implements and evaluates a plan of patient care; prescribes and dispenses medication; refers to and consults with

appropriate Healthcare Practitioners; and bills and is able to be paid in the Nurse Practitioner's own name under the laws of the state or jurisdiction where the services are rendered.

4. **Surgical Assistant:** A person legally licensed as a Registered Surgical Assistant, Registered Surgical Technologist or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license, is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient, and under the supervision of a Physician: passes instruments during surgical procedures; keeps a sterile field during surgical procedures; and has been certified by recognized professional associations of Certified Surgical Assistants.

Non-Plan Skilled Nursing Facility means a Skilled Nursing Facility that does not have an agreement with Blue Cross Blue Shield of Illinois but has been certified in accordance with guidelines established by Medicare. No benefits under the Plan are provided for services received in a Non-Plan Skilled Nursing Facility.

Call or write the Fund Office before admission to a Skilled Nursing Facility to verify that the facility is a Plan Skilled Nursing Facility.

Non-PPO Hospital means a Hospital that is not included in the Blue Cross Blue Shield of Illinois PPO Network at the time services are rendered.

Non-PPO Physician means a Physician who is not included in the Blue Cross Blue Shield of Illinois PPO Network at the time services are rendered.

Outpatient means that you or your Dependent is receiving treatment while not an Inpatient.

Participant means either an Employee or the Employee's Dependent who has met the eligibility requirements to participate in the Plan and is enrolled in Plan coverage.

Physician and/or Surgeon means any individual licensed to practice medicine and perform general surgery (MD) in the State where the license is given, and a Doctor of Osteopathy (DO) and Chiropractor (DC) licensed to practice medicine in the State where the license is given, and who acts within the scope of such license, and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Plan Approved Dialysis Facility means a facility (other than a Hospital) that:

1. Has the primary function of treatment and/or provision of maintenance and/or training dialysis on an ambulatory basis for renal-dialysis patients,
2. Is duly licensed by the appropriate governmental authority to provide such services, and
3. Is approved by Blue Cross Blue Shield MSA.

Plan/PPO Ambulatory Surgical Facility means a Preferred Provider Organization Ambulatory Surgical Facility that has been approved by Blue Cross Blue Shield of Illinois to provide services to the member at the time services are rendered.

Plan/PPO Hospital means a Hospital that has a written agreement with Blue Cross Blue Shield of Illinois to provide services to the member at the time services are rendered.

Call the Fund Office at 1-708-449-7373 or Blue Cross Blue Shield at 1-800-810-BLUE (2583) or visit the Blue Cross Blue Shield of Illinois website at www.bcbsil.com to find out if a particular Hospital is a Plan/PPO Hospital.

Plan/PPO Skilled Nursing Facility means a Skilled Nursing Facility that has a written agreement with Blue Cross Blue Shield of Illinois to provide services to you or your Dependents at the time services are rendered.

Call or write the Fund Office before admission to a Skilled Nursing Facility to verify that the facility is a Plan/PPO Skilled Nursing Facility.

Prescription Drugs may be either Brand Name Drugs or Generic Drugs. Both types of drugs may be listed on the CVS Caremark Formulary.

1. **A Brand Name Drug** is a new drug that has come to market for the first time, for which the drug company that manufactures it has a patent to be the sole manufacturer for a particular number of years.
2. **A Generic Drug** is the equivalent of the Brand Name Drug produced by other manufacturers after the patent has expired. A Generic Drug usually serves the same purpose as the original medication, but generally costs less than the Brand Name Drug.
3. **A Formulary Drug List** is the preferred drug list prepared by CVS Caremark that lists both Generic and Brand Name Drugs that can be used to treat a condition or symptom. The list is compiled by a team of Pharmacists and Physicians who review the Formulary Drug List and make changes as necessary and as new drugs come to market.

Provider means any healthcare facility such as a Hospital or Skilled Nursing Care Facility, or any person such as a Physician duly licensed to render covered services to you or your Dependents when Medically Necessary. Providers include the following: Ambulatory Surgical Facility, Dental Hygienist, Dentist, Dialysis Facility, Hospital, occupational, speech, or physical therapist, pharmacy, Physician, Registered Nurse or Licensed Practical Nurse or Skilled Nursing Care Facility.

Sickness means illness or disease that causes loss covered by the Fund. Losses incurred because of pregnancy, childbirth and related medical conditions are covered under the Fund to the same extent as any other Sickness.

Skilled Nursing Facility means an institution or a distinct part of an institution that:

1. Has a transfer agreement with one or more Hospitals,
2. Is primarily engaged in providing comprehensive post-acute Hospital and rehabilitative Inpatient care, and
3. Is duly licensed by the appropriate governmental authority to provide such services.

Skilled Nursing Facility does not mean institutions that provide only minimum care, custodial care services, ambulatory or part-time care services or institutions that primarily provide for the care and treatment of Mental or Nervous Disorders, Pulmonary Tuberculosis or Substance Abuse.

Substance Abuse means the uncontrollable or excessive abuse of addictive substances including but not limited to: alcohol, cocaine, morphine, heroin, opium, cannabis and other barbiturates, amphetamines, tranquilizers and/or hallucinogens and the resultant physiological and/or psychological dependency that develops with continued use of such addictive substances requiring medical care as determined by a Physician.

Appendix A: DURABLE MEDICAL EQUIPMENT AND SUPPLIES

The Trustees have the authority and discretion to determine what constitutes Durable Medical Equipment and covered supplies for items not listed, and when to rent, lease or purchase the equipment.

Covered Supplies

Alternating Pressure Point Pads
Apnea Monitor
Blood Plasma or Whole Blood
Bone Growth Stimulators
Braces (except dental)
Canes and Crutches
Casts, Splints, Binders (such as cervical collars, knee braces or crutches)
Compression Garment (inflatable & non-inflatable including surgical stockings)
Custom Foot Orthotics (ordered by DPM, MD, OD only)
Electro-Larynx
Glucose Monitor
Hospital Beds (manual or electric)
Infusion Pumps (enteral or parenteral nutritional therapy only)
Intermittent Compression Units
Kidney Hemodialysis Machines
Muscle Stimulators (used during therapy)
Nasal CPAP
Nebulizers
Nerve Stimulator
Orthotic Devices
Ostomy Supplies (for colostomy or ileostomy)
Oxygen and Rental Equipment (for the administration of oxygen)
Pacemakers
Penile Implants
Prosthesis, Artificial Limbs or Eyes (except replacement thereof)
Radium, Radioactive Isotopes and X-ray Therapy
Surgical Bras (post-mastectomy)
Surgical Dressing (therapeutic and protective coverings applied to wounds or lesions either on the skin or opening to the skin in connection with a surgical procedure performed by a Surgeon, including: adhesive tape, roll gauze, bandages, and disposable compression material)

Therapeutic Mattress
Traction Equipment
Ultra-Violet Equipment
Ventilators
Walkers
Wheel chairs

Non-Covered

Automatic Blood Pressure Monitor
Bathtub or Shower Seat/Bench/Chair
Beds/Lounge
Biofeedback Equipment
Birth Control Devices
Blood Pressure Cuff
Breast Pumps
Cervical Pillow
Circulators
Colonic Irrigation Units
Communication Devices
Environmental Equipment including: Air Cleaner, Air Filter, Humidifier, Air Conditioner, Dehumidifier, Precipitator, and Vaporizers
Exercise Equipment
Exercycle
Food Blenders
Gravetonical Traction Device
Handrails
Heating Pads
Hot Tubs
Hydraulic Lifts
Lifts, Transfer Boards/Bench
Massage Devices
Nocturnal Enuresis Devices
Sauna Baths/Sitz Baths
Shoe Inserts, Arch Supports, Heel Lifts
Water Piks
Whirlpools/Whirlpool Equipment
Wigs/Toupees