

Sheet Metal Workers Local Union No. 32 Health and Welfare Fund

SUMMARY PLAN DESCRIPTION

EFFECTIVE JANUARY 1, 2008

**SHEET METALWORKERS
LOCAL UNION NO. 32
HEALTH AND WELFARE PLAN**

To All Eligible Participants:

At a time when health care is one of our nation's greatest priorities, the Board of Trustees of your Plan continues to afford you and your family financial protection through health coverage provided by the Plan. We are pleased to present you with this updated booklet, which describes the major features of your Plan. The terms of this booklet are effective January 1, 2008.

This booklet is designed to give you an easy-to-read reference about the Plan. It covers the benefits, eligibility rules, claim procedures and the administration of the Plan as required by federal law. According to law, the Plan is governed by a Plan Document and other agreements (which are always available for your inspection), and we have tried to describe the benefits here just as they are written in those documents. However, if there is any difference between the terms of this booklet and those of the Plan documents, the Plan or contract provisions will control.

We believe the continued success of our program is due to the excellent cooperation from you, the Employers and the Union. You can be assured that the Trustees will continue to administer the Plan so that you can receive the most comprehensive benefits possible within the resources available to the Plan.

Keep this booklet in a safe place for quick reference after you have read it. Of course, if you have any questions about your eligibility or the benefits to which you are entitled, please contact the Administrative Manager. Finally, please notify the Plan promptly when your beneficiary or current address has changed.

Sincerely,

BOARD OF TRUSTEES

BOARD OF TRUSTEES

UNION TRUSTEES

Larry Stewart
Harley McDougall
Robert Levy
David Puittinen

EMPLOYER TRUSTEES

William Medlin
William H. Marvel, Jr.

ADMINISTRATIVE MANAGER

Zenith Administrators, Inc.
P.O. Box 721380
Houston, Texas 77272-1380
Tel. (866) 521-7632
Fax No. (713) 219-1299
Local phone number for Florida office is (877) 816-0162

FUND COUNSEL

Howard S. Susskind, Esq.
Sugarman & Susskind, PA
100 Miracle Mile, Suite 300
Coral Gables, Florida 33134
Tel. (305) 529-2801
Fax No. (305) 447-8115

BENEFIT CONSULTANT

Frank K. Dalrymple, Jr.
2141 Pinetree Circle, N.E.
Gainesville, Georgia 30501
Tel. (770) 297-7890
Fax No. (770) 297-8150

HMO CLAIMS ADMINISTRATION

United Healthcare
13621 NW 12th Street
Sunrise, Florida 33323
Tel. (954) 858-4435
Fax No. (954) 858-3818

TABLE OF CONTENTS

IMPORTANT INFORMATION ABOUT THE PLAN	4
I. YOUR ELIGIBILITY FOR BENEFITS	8
1. Bargaining Unit Employees	8
2. Dependents	10
3. Non-Bargaining Unit Employees	10
4. Retired Employees	11
II. PLAN PROVISIONS APPLICABLE TO ALL ELIGIBLE PARTICIPANTS	13
Continuation of Health, Dental and Vision Coverages..	13
Maternity Stay Notice	16
Certificate of Creditable Coverage	17
The Women's Health and Cancer Rights Act of 1998	17
Mental Health Parity Act of 1996	18
Uniformed Services Employment and Reemployment Rights Act of 1994	18
Family Medical Leave Act ..	19
III. GENERAL DEFINITIONS	21
IV. HMO COVERAGE	24
V. SELF FUNDED BENEFITS DENTAL AND VISION	33
VI. GENERAL INFORMATION	41
Coordination of Benefits ..	41
Subrogation (Dental and Vision Only)	42
Medicare	43
Claim Forms and How to File a Claim	44
Other Provisions	44
VII. CLAIMS PROCEDURE AND REVIEW OF CLAIMS (APPEAL PROCEDURE)	47
VIII. HIPPA RIGHTS, PRIVACY AND SECURITY PROVISIONS	56
IX. STATEMENT OF ERISA RIGHTS	61
X. SCHEDULE OF BENEFITS	64

IMPORTANT INFORMATION ABOUT THE PLAN

This employee benefit plan is intended to comply with the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

PLAN NAME

Sheet Metal Workers Local Union No. 32 Health and Welfare Plan.

PLAN YEAR

The year upon which the records of the Plan are kept is July 1st through June 30th.

TYPE OF PLAN

This plan offers health, hospitalization, dental and vision benefits to eligible participants.

ADMINISTRATION

A Board of Trustees is responsible for the administration of this Plan. The Board of Trustees consists of both Union and Employer representatives, selected by the Union and the Employers who have entered into collective bargaining agreements, which relate to the Plan. A complete list of Employers as well as information as to a particular Employer and the Employer's address may be obtained upon written request to the Administrative Manager and are available for examination.

The names and addresses of the individual Trustees are as follows:

UNION TRUSTEES

Harley G. McDougall
P.O. Box 848245
Hollywood, Florida 33084
Medley, Florida 33178

Larry Stewart
Business Manager
c/o Sheet Metal Local 32
20375 NE 15th Court
North Miami Beach, Florida 33179

David A. Puittinen
17300 Southwest 117 Avenue
Miami, Florida 33177-2202

Robert Levy
10201 Orange Drive
Davie, Florida 33328

EMPLOYER TRUSTEES

William Medlin
Sheet Metal Experts, Inc.
8986 Northwest 105th Way

William H. Marvel, Jr.
Bohnert Sheet Metal
2225 NW 76th Street
Miami, Florida 33147

ADMINISTRATIVE MANAGER

The day to day administration of the Plan and payment of Dental and Vision Claims are handled by Zenith Administrators, located at:

P.O. Box 721380
Houston, Texas 77272-1380

CLAIMS ADMINISTRATION

Customer service and all health claims for other than Dental and Vision are handled by United Healthcare located at:

13621 NW 12th Street
Sunrise, Florida 33323

The Board of Trustees has broad discretionary authority to:

- construe the terms of the Plan,
- determine the status and rights of participants, beneficiaries and other persons,
- make rulings and prescribe procedures,
- gather needed information,
- exercise all of the power and authority contemplated by ERISA with respect to the Plan,
- employ or appoint persons to help or advise in any administrative functions,
- appoint investment managers and trustees, and
- do all other things needed to operate, manage and administer the Plan.

The Plan has other fiduciaries, advisors and service providers. The Board of Trustees may allocate fiduciary responsibility among the Plan's fiduciaries and may delegate responsibilities to others. Any allocation or delegation must be done in writing and kept with the records of the Plan.

Each fiduciary is solely responsible for its own improper acts or omissions. Except to the extent required by ERISA, no fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being, a fiduciary. However, a fiduciary may be liable for a breach of fiduciary responsibility of another plan fiduciary, to the extent provided in ERISA.

Dental benefits and vision benefits are self-funded.

IDENTIFICATION NUMBERS

The plan number assigned to this Plan by the Board of Trustees on instructions of the Internal Revenue Service is 501. The identification number assigned to the Board of Trustees by the Internal Revenue Service is 65-6088549. If you want to write to the Internal Revenue Service or the U.S. Department of Labor about this Plan, you must use these numbers.

SOURCE OF CONTRIBUTIONS

All contributions to the Plan are made by Employers in accordance with Collective Bargaining Agreements with employee representatives. The Collective Bargaining Agreements require contributions to the Plan at fixed rates per hour. The Plan also receives contributions on behalf of certain non-collectively bargaining participants pursuant to written participation agreements between the Plan and Employers.

A copy of any of the agreements may be obtained by Plan participants or their beneficiaries upon written request to the Administrative Manager or they may be inspected at the Administrative Manager's office during normal business hours.

AGENT FOR SERVICE OF LEGAL PROCESS

The Plan's agent for service of legal process is:

Howard S. Susskind, Esq.
Sugarman & Susskind, P.A.
Suite 300 - 100 Miracle Mile
Coral Gables, Florida 33134

Legal papers may also be served on any Trustee or upon the Administrative Manager.

FUNDING MEDIUM

Benefits and HMO premium are provided from the Plan's assets which are accumulated under the provisions of the Collective Bargaining Agreement and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered persons and defraying reasonable administrative expenses. All assets and reserves are held in custody and invested by the Board of Trustees pursuant to fiduciary standards required by federal law.

PLAN INFORMATION

The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits are briefly described in this booklet.

PLAN AMENDMENT AND/OR TERMINATION

The right to amend, modify, suspend and/or terminate the Plan in whole or in part at any time is reserved to the Board of Trustees and to the Employers and the Union who are signatory to the Plan's Trust Agreement. Circumstances under which the Plan may be terminated include, but are not limited to:

- (a) When there are no longer sufficient assets to continue the benefits of the Plan. In this regard, the Board of Trustees will first attempt to amend the Plan's benefits, alter or postpone the method of paying benefits or take other actions consistent with its obligation to maintain the maximum possible benefits within the limits of the Plan's resources;
- (b) When there are no longer any employers who are required to make contributions under the appropriate Collective Bargaining Agreement;
- (c) When the last surviving participant or beneficiary entitled to receive benefits has died;
- (d) With respect to a particular Employer, when that Employer ceases to be a contributing Employer according to the Plan's Trust Agreement, or
- (e) With respect to a particular Employee, when that Employee ceases to be an eligible Employee according to the Plan's Rules and Regulations.

If the Plan were to terminate, the Board of Trustees will within the limits of the Plan's resources, adopt a plan to discharge all outstanding obligations and to provide that all remaining Plan assets be used in a manner which best carries out the basic purpose for which the Plan was established.

The Plans may be amended by the Board of Trustees upon majority vote of the Trustees in attendance and voting at that time. All amendments will be in writing and signed by the Trustees. A Summary of Plan changes describing any material changes or modifications will be distributed to all Plan participants.

If any amendments to the Plan result in a material reduction of benefits under the Plan, then you will receive notification of these reductions within 60 days of the date of adoption of the amendment.

CLAIMS FILING AND APPEAL

Refer to the section entitled How to File a Claim for information on filing claims. Refer to the section entitled Claims Appeal Procedures for information on appealing denied claims.

I.

YOUR ELIGIBILITY FOR BENEFITS

1. ALL BARGAINING UNIT EMPLOYEES

GENERAL RULE

Eligibility for benefits is strictly conditional upon you working for or available for work with a contributory employer. This condition does not apply in the event you are unable to work due to illness, disability or retirement. You will be presumed to be not available for work if you are working at the trade full time for a non-signatory employer.

TRANSITIONAL RULE

An employee will be eligible on July 1, 2007, if he meets EITHER of the following conditions of hours worked for contributing employer(s):

(a) 375 hours worked in the months of January, February and March of 2007; or

(b) 500 hours worked in January, February, March, April, May and June of 2007.

Eligibility provided under this section shall be on a one-time basis only and shall continue until midnight September 30, 2007. On October 1, further eligibility shall be determined as provided in the rules shown below.

INITIAL ELIGIBILITY

For those not eligible for coverage on July 1, 2007, you will become initially eligible for benefits on the first day of the first month following the month in which contributions for a minimum of 500 hours have been made on your behalf by a contributing employer during any 6 consecutive calendar months during which such hours were worked.

CONTINUED ELIGIBILITY

For the purpose of maintaining eligibility, you may accumulate hours of contributions among the following:

(a) Hours worked for which an employer makes contributions;

(b) Reciprocity hours, pursuant to a reciprocity agreement approved by the Board of Trustees;

(c) Self-contributions, if the employee is available for work.

(d) Disability Hours.

HOW OUR ELIGIBILITY CAN BE TERMINATED

A bargaining unit employee's eligibility will terminate on the first to occur of the following events:

(a) The last day of the fourth month during which no hours of contributions are paid and received on your behalf; or

(b) October 1 of any year if you have not had 1400 hours of more of paid contributions received during the preceding 12 month period from July 1 to June 30 provided, however, this provision shall not apply in the event that you were not eligible as of the preceding July 1 or if your coverage was reinstated during the preceding 12 month period from July 1 to June 30. The first annual termination under these rules will not take place until October 1, 2008; or

(c) The date the Trustees terminate this Plan of Benefits.

HOW YOUR ELIGIBILITY CAN BE REINSTATED

After termination of eligibility, you may again become eligible on the first day of the month following 500 hours of paid contributions within a consecutive six (6) month period. You cannot make self-contributions or disability hours to reinstate.

HOW YOU CAN MAKE SELF CONTRIBUTIONS TO CONTINUE YOUR ELIGIBILITY

For the purpose of continued eligibility, bargaining unit employees can make self contributions to the Plan. You can make such contributions if you have at least 1200 hours of paid contributions during the 12 month period July 1 thru June 30 of the year under review; and are available for work for a Contributing Employer in the trade and geographic area of the Plan.

You may make a self-payment (up to 200 hours) to continue eligibility.

The Fund will send the employee a notice informing him that his eligibility will terminate if he does not make the self-payment, and the amount of the required self-payment necessary to maintain his eligibility. If an employee chooses to make a self-payment instead of a COBRA payment, he must make the regular self-payment to the Fund by the due date stated on the notice sent by the Fund. If an Employee fails to make the required self payment by the due date, eligibility will be terminated unless he is eligible for, and elects to make a COBRA payment within the allowable election period.

DISABILITY CREDITS

For the purpose of maintaining continued eligibility, bargaining unit employees will be credited with 117 disability hours for each calendar month of proven Disability up to a maximum of 6 months in any 12 month period. A month of proven Disability is any calendar month in which the employee can medically prove that he has been totally disabled for a minimum of twenty consecutive days.

Disability credit shall also be granted if you are eligible but disabled at the time of an annual termination (October 1) on the basis of 117 hours for each month of proven disability

during the prior 12 month period, up to a combined maximum of 6 months in a 12 month period under this section.

If you die while covered, your dependents shall remain eligible for the balance of your eligibility including any unused disability hours as if you had not died.

SURVIVING SPOUSE

Surviving Spouses of deceased eligible employees may continue coverage beyond the employee's coverage period until they are eligible for Medicare by making the required self-payment, PROVIDED that the deceased employee was either vested or receiving a pension benefit from the Sheet Metal Workers Local Union No. 32 Pension Fund OR the Sheet Metal Workers National Pension Fund.

2. DEPENDENTS' ELIGIBILITY

Your Dependents' are eligible for benefits on the day you become eligible for benefits under "Initial Eligibility" (see above), or on the day you first acquire a dependent. Refer to the "Definitions" section for the meaning of Dependent.

TERMINATION OF DEPENDENT'S ELIGIBILITY

Benefits for your Dependents will automatically terminate on the date your benefits terminate, or the date the Dependent no longer qualifies as a dependent.

3. NON-BARGAINING UNIT EMPLOYEE

(INCLUDING SALARIED CORPORATE OFFICERS AND SELF-EMPLOYED INDIVIDUALS)

If you are a non-bargaining unit employee, corporate officer, or a self-employed individual, and your employer has a collective bargaining agree in effect with Local Union 32, you may participate in the Plan, subject to the following provisions:

APPLICATION FOR PARTICIPATION

In order to participate, you (or your employer, as applicable) must first apply to the Board of Trustees, who reserves the right to reject any application. If the Board of Trustees approves your application, you will then be required to sign a Participation Agreement that documents your participation in the Plan.

INITIAL ELIGIBILITY

Once you have been approved by the Board of Trustees to participate in the Plan, you will become initially eligible for benefits on the first day of the first month following the month in which contributions for a minimum of 500 hours have been made on your behalf by a contributing employer during any 6 consecutive calendar months during which such hours were worked.

NO SELF-CONTRIBUTIONS OR DISABILITY HOURS

Non-bargaining unit employees are not entitled to make regular self-contributions or be credited with disability hours to continue their eligibility. However, non-bargaining employees and their dependents are entitled to COBRA coverage under the same rules that apply to bargaining unit employees.

TERMINATION OF ELIGIBILITY

Non-bargaining unit will cease to be eligible for benefits on the first to occur of the following dates:

- (a) The last day of the month during which the employee's employment terminates;
- (b) The last day of any month for which an on-time contribution was made;
- (c) The last day of the month in which the Collective Bargaining Agreement or Participation Agreement covering the employee is terminated or expires;
- (d) The date the Trustees terminate coverage for non-bargaining unit employees under this Plan of Benefits;
- (e) The date the Trustees terminate this Plan of Benefits;
- (f) The date of the employee's death; or
- (g) With respect to specific benefits or types of coverage, the date the Trustees decide to limit or eliminate same. If your benefits terminate, benefits for your Dependents will automatically terminate on the same date, or the date your Dependent no longer qualifies as a Dependent, if earlier.

SPECIAL ELIGIBILITY RULES

Normally you may enroll an existing Dependent only during an open enrollment period. However, there are conditions under which a Dependent may be enrolled at any time. If you have a Dependent covered under another group health plan and coverage under that group health plan terminates, your Dependent may enroll under this health plan within 30 days of loss of other coverage. A new Dependent may be added at any time as more fully explained elsewhere in this document.

4. RETIRED EMPLOYEES

In order to be eligible for retiree coverage under this Plan an employee must have been eligible under this Plan immediately preceding his retirement from the industry and be a retiree under the Sheet Metal Workers Local Union No. 32 Pension Fund or the Sheet Metal Workers National Pension Fund.

INITIAL ELIGIBILITY

Provided that all of the requirements of this section are met, a retiree's eligibility for retiree coverage will be effective on the first day of the month following the 4 month period during which the Plan receives no contributions on his behalf.

CONTINUED ELIGIBILITY

Retiree's continued eligibility for benefits shall be determined on a monthly basis. Retirees will remain eligible for benefits for each month for which they make timely and sufficient contributions on their behalf. Retiree self-contributions must be received in the Plan Administrator's Office no later than the 20th day of each month preceding the month for which coverage will be effective.

RETIREE SELF-CONTRIBUTIONS - AMOUNT

The amount of the retiree self-contributions shall be determined by the Board of Trustees from time to time.

TERMINATION OF ELIGIBILITY

A retiree's benefits will automatically terminate on the earliest to occur of the following dates:

- (a) The date that the retiree is no longer "retired" as that term is defined in the Pension Plan Document.
- (b) The last day of the month for which an on-time self-contribution has been made for Retiree Coverage.
- (c) The date the Trustees terminate this Plan of Benefits.
- (d) The date the Trustees terminate benefits for retirees.
- (e) The date of the retiree's death; or
- (f) With respect to specific benefits or types of coverage, the date the Trustees decide to limit or eliminate same.

II. PLAN PROVISIONS APPLICABLE TO ALL ELIGIBLE PARTICIPANTS

HOW TO CONTINUE YOUR ELIGIBILITY COBRA CONTINUATION OF HEALTH COVERAGE

Federal law ("COBRA") mandates that employer-sponsored group plans provide individuals with the option of continuing their health coverage when their coverage terminates under the group plan.

The rules relative to COBRA continuation of health coverage are discussed below. **It is important that all family members be aware of these provisions in the event coverage terminates.** Health coverage includes medical, dental, and vision coverage.

1. ELIGIBILITY FOR COBRA COVERAGE

An employee or Dependent whose coverage is terminated due to a "qualifying event" as described below may elect COBRA coverage. COBRA coverage may not be elected by anyone who is not a covered person at the time termination occurs.

2. QUALIFYING EVENTS

You and your eligible Dependents have the right to continue group health coverage if it terminates for certain reasons, **as long as you or your Dependents make the required self-payment of premiums.**

For Employees and Dependents, continuation coverage is available if coverage terminates due to:

- (a) Termination of the Employee's employment (for any reason other than gross misconduct by the employee); or
- (b) A reduction in hours worked by the Employee.

For Dependents, continuation coverage is also available if coverage terminates due to:

- (c) Death of the Employee;
- (d) Divorce or legal separation of the Employee and spouse;
- (e) A Dependent child ceasing to be a Dependent, as defined under the Plan; or
- (f) A Dependent ceasing to be eligible due to the Employee becoming entitled to Medicare Part A or Part B.

These occurrences are referred to as "Qualifying Events".

3. NOTICE REQUIREMENTS

If there is a loss of Dependents coverage due to 2(d) or (e) above or the award of disability determination by Social Security Administration, you, your Dependent, or your legal representative must notify the Administrative Manager in writing within sixty (60) days of the event so that the Administrative Manager can provide you and your covered Dependents with notices on COBRA continuation coverage rights, and the terms which apply to the coverage. If you fail

to give timely notice of events in items (d) or (e) above, you may lose your right to COBRA coverage. If events in items 2(a), (b), (c) or (f) above occur, your Employer is required to notify the Administrative Manager within 30 days of the event. The Administrative Manager has fourteen days after receiving notice of one of these events from you or your employer to notify you of your right to continuation coverage. However, if any of those events do occur, you or your Dependents should notify the Administrative Manager as well. You should try to give notification within 7 days of the qualifying event to assure there is no lapse in coverage. If you do not choose COBRA continuation coverage, your group health coverage will terminate in accordance with the provisions in the booklet. If you choose continuation coverage, you will have the same health coverage for which you are currently eligible.

4. ELECTION REQUIREMENTS

You, your Dependents, or your legal representative must elect to make self payment of premiums within the later of 60 days after your eligibility terminates or within 60 days from the date you are notified by the Administrative Manager of your right to maintain your eligibility through COBRA. If an election is not made and postmarked within the time periods stated in the notice, you cannot continue coverage under this Plan.

5. SELF PAYMENT OF COBRA PREMIUMS

Self payment, if elected, must be made from the date of termination. No lapse in coverage is permitted.

(a) If you, or your legal representative, elect to continue coverage within 60 days after your eligibility terminates, the initial premiums due for coverage must be postmarked and sent to the Administrative Manager within 45 days after the election; this includes premiums required for months of coverage between the termination date of coverage and the date the initial premium is due.

(b) After the initial election and payment of premiums, future payments must be postmarked and sent to the Administrative Manager before the first day of the month for which coverage is to be provided. There is a 30-day grace period for receipt of your payment. Once you are initially notified of your obligation to pay COBRA premiums, you will not receive any further notices from the Administrative Manager.

(c) The premium rate for continuation coverage will be determined according to federal law and is guaranteed not to change during the 12-month period established by the Board of Trustees. The premium rates are subject to change at the beginning of each Plan Year. They may be changed during the year only if benefit modifications are made.

(d) If benefits provided to active Employees and/or their Dependents changes, your continuation coverage will also change.

(e) You will be notified of any change in premium rate that you are required to pay.

6. MAXIMUM PERIOD ALLOWED UNDER CONTINUATION COVERAGE

(a) Up to 18 months (maximum) are allowed from the date coverage would have otherwise terminated, if coverage is being continued for you and your Dependents because you stopped working, including retirement or reduced hours of employment for any reason (other than the gross misconduct of the Employee).

(b) 29 Months - You will be allowed to elect continuation coverage for up to 29 months provided:

1. You are determined to be disabled under the Social Security Act either at the time of loss of coverage or during the first 60 days of coverage continuation, and

2. You provide notice to the Plan of the Social Security Disability determination within 60 days of receipt and within the first 18 months of coverage.

This coverage may be extended for the disabled person and any other qualified beneficiaries covered under COBRA at the end of the first 18 months. The cost of the additional 11 months after the first 18 months can be 150% of the regular COBRA premium

c) Up to 36 months (maximum) from the date coverage would have otherwise terminated, if coverage is being continued for your spouse and/or Dependent child(ren) for reasons other than termination of employment or reduction in hours.

If a covered Employee becomes entitled to Medicare after an initial qualifying event, then continuation coverage for the Employee's Dependent may continue for the greater of:

(a) 18 months from the date of the employee's termination of coverage under the Plan; or

(b) 36 months from the date the Employee initially became eligible for Medicare.

With respect to covered Dependents, if another qualifying event occurs within 18 months after the Employee loses coverage due to termination of employment or reduction in hours, then continuation coverage for the Employee's Dependents will continue until the date which is 36 months after the Employee's initial loss of coverage due to termination of employment or reduction in hours.

However, continuation coverage under these provisions may be terminated at an earlier date, as provided in Item 7 below.

If you do not elect to pay premiums for COBRA continuation coverage on a timely basis, you will no longer be covered under the Plan and any claims filed during the election period or following termination for non-payment of premium will not be paid by the Plan. Reinstatement of coverage is not permitted.

Full details of COBRA continuation coverage will be furnished to you and/or your Dependents when the Administrative Manager receives notice that one of the Qualifying Events described in Item 2 above has occurred. Therefore, we urge you and your Dependents to contact the Administrative Manager as soon as possible after the occurrence of one of those events.

7. TERMINATION OF COBRA CONTINUATION COVERAGE (ALL INDIVIDUALS)

COBRA continuation coverage will terminate on the earliest of:

- (a) The first day of the month for which premium is not paid on time;
- (b) The date you become entitled to Medicare Part A or part B;
- (c) The day the Plan stops providing group health coverage;
- (d) The day you become covered under another group health plan;
- (e) The date your spouse or child ceases to be a "Dependent" as defined by the Plan including your failure to comply with the Plan's Eligibility Rules, or;
- (f) In the case of extended disability coverage when Social Security makes a final determination that the disability no longer exists or the covered person fails to notify the Fund Office of such determination within 30 days.

You will receive Certificate of Creditable coverage once coverage ends.

8. NEWLY ACQUIRED DEPENDENTS

If, while under continuation coverage you acquire a new Dependent, your Dependent will be eligible for this continuation coverage provided the required premium is paid, the Dependent is properly enrolled and you notify the Administrative Manager of your newly acquired Dependent within 30 days.

If events 2 (c) and 2 (d) should subsequently occur for your newly acquired Dependent spouse, such spouse will not be entitled to continue their coverage. If another qualifying event described in 6 should subsequently occur for your child who is born, adopted or placed for adoption as a newly acquired Dependent, coverage will be continued in the manner indicated in 6.

CERTIFICATE OF CREDITABLE COVERAGE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law requiring most group health plans to provide certificates automatically when a plan participant's Healthcare coverage terminates. The primary purpose of the certificate is to show the amount of "creditable coverage" that you and/or your Dependent had under the group health plan. The "creditable coverage" is used to reduce or eliminate the length of time that any pre-existing condition limitation might apply in a new plan.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

This plan is subject to the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA). Accordingly, benefits for a hospital stay in connection with childbirth (for the mother and the newborn) may not be restricted below certain minimums provided by the NMHPA. Specifically, in cases of a vaginal delivery, the mother and newborn child may have a hospital stay of at least 48 hours; and in cases of a cesarean delivery, the mother and newborn may have a hospital stay of at least 96 hours. If, however, the mother, attending physician and the hospital all agree a shorter length of stay is sufficient, the mother and newborn child may leave the hospital prior to the standard 48 hours or 96 hours prescribed by the NMHPA. Additionally, no provider shall be required to obtain prior authorization for prescribing a maternity hospital stay unless it exceeds the 48 or 96 hours required by NMHPA.

WOMEN'S HEALTH AND CANCER RIGHTS PROTECTION ACT OF 1998

This plan is subject to the Women's Health and Cancer Rights Act of 1998 (WHCRA). Accordingly, coverage shall be provided, as required by WHCRA, to any Covered Employee or Dependent who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, for:

- (1) Reconstruction of the breast on which the mastectomy has been performed;
- (2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- (3) Prosthesis and physical complications of all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as set forth herein, and as are consistent with those established for other benefits provided hereunder.

Notice shall be sent annually to all Covered Employees and Dependents hereunder regarding rights protected under the Women's Health and Cancer Rights of 1998.

MENTAL HEALTH PARITY ACT OF 1996

This plan is subject to the Mental Health Parity Act of 1996. Accordingly, no lifetime or annual limit shall apply, in accordance with MHPA, to mental health benefits if no such lifetime or annual limit applies to substantially all medical and surgical benefits provided hereunder. To the extent that any lifetime or annual limitation applies to substantially all medical and surgical benefits provided hereunder, no distinction shall be made if such limitation(s) is to apply to mental health benefits in the application of such limitation(s) to the relevant medical and surgical benefits and to mental health benefits provided hereunder. Alternatively, no lifetime or annual limitation shall apply to mental health benefits provided hereunder that is less than that which applies to substantially all medical and surgical benefits.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

This plan is subject to the Uniformed Services Employment and Reemployment Rights Act of 1994. Accordingly:

(a) Any Participant who is absent from a position of employment by reason of Service in the Uniformed Services, may elect to continue coverage during the period of such absence, up to a maximum period defined as the lesser of:

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

(2) The period beginning on the date upon which the Participant's absence begins and ending on the day after the date upon which the Participant fails to apply for or return to a position of employment as required under the Act.

(b) A Covered Employee who elects to continue coverage hereunder shall be required to pay not more than 102 percent of the full premium hereunder, except that in the case of a Covered Employee, who performs service in the Uniformed Services for less than 31 days, said Covered Employee shall not be required to make any premium payments.

(c) "Service in the Uniformed Services" shall mean the performance of duty on a voluntary or involuntary basis in a Uniformed Service that includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty and a period for which a Covered Employee is absent for examination used to determine fitness for duty. "Uniformed Services" shall include the Armed Forces, the Army National Guard and the Air National Guard, the commissioned corps of the

Public Health Service and any other category of persons designated by the President of the United States of America in time of war or emergency.

FAMILY MEDICAL LEAVE ACT

Employees covered under this Plan are entitled to coverage during periods of absence from employment for a period of up to three months in any calendar year.

The term "Eligible Employee" shall mean an Employee of an Employer who:

(1) Has been employed by an Employer during the prior twelve month period; and

(2) Has been employed for at least 1250 hours during the twelve month period immediately preceding the commencement of leave under this Article; and

(3) Is employed at a work site where 50 or more Employees are employed by the Employer within 75 miles of that work site.

The term "Authorized Leave" shall mean leave from the Employer for the following specified reasons:

(1) For the birth of a child, and to care for a newborn child;

(2) For the placement with the Employee of a child for adoption or foster care;

(3) To care for the Employee's spouse, child or parent with a serious health condition; and

(4) Because of a serious health condition that makes the Employee unable to perform the function of any employee's job.

The Employer of an eligible Employee who is granted authorized leave for any of the reasons set forth above shall be required to make contributions to this Plan during periods of such authorized leave for a period not to exceed three months in any calendar year. The amount of contributions required to be paid by the Employer shall be the minimum number of hours required for eligibility for bargaining unit employees. The Employer's remittance of contributions on behalf of any Eligible Employee on authorized leave shall be accompanied by a notice from the Employer to the Board of Trustees advising that the eligible Employee is on Authorized Leave.

In the event that an Employer fails to make payment of the contributions due on behalf of its Employees on Authorized Leave, such failure to pay shall be considered as a delinquency under the terms of the applicable Collective Bargaining Agreement and subject the Employer to all of the remedies available to the Trustees for collection of such delinquency pursuant to the Agreement and Declaration of Trust and through Collective Bargaining Agreement.

In the event that the Plan provides for the co-payment by the Eligible Employee of a portion of the total contributions required to be paid for continuing coverage, including coverage for those periods during which the Eligible Employee is not on authorized leave, then the Eligible Employee remains obligated to make payment of such co-contributions which are due during the period of Authorized Leave. Should an Eligible Employee fail to make payment of the share of the contributions required to maintain coverage, the eligibility of the Eligible Employee on authorized leave may be terminated. If the Eligible Employee fails to make such payment, the Employer's contribution obligation under this Article may be suspended for the duration of the Eligible Employee's authorized leave. Nothing in this section shall be construed to prohibit the Employer from making payment of any Employee required co-contribution.

Coordination of Authorized Leave and Continuation Coverage

Authorized leave under this Plan is not a "qualifying event" as set forth in the Eligibility for Continuation Coverage Following Termination (COBRA) section. If an Employee fails, however, to return to work at the end of authorized leave, such failure shall serve to terminate the employer's obligations to make payment of contributions under this Article and may constitute a Qualifying Event under COBRA.

III. GENERAL DEFINITIONS

A **CONTRIBUTING EMPLOYER** is an Employer who is required, under the terms of a Collective Bargaining Agreement, to contribute to the Plan and also the Union with respect to its employees for whom contributions are made to the Plan.

Your **DEPENDENT** means (1) your spouse, not legally separated from you; (2) your unmarried child or children from birth until December 31 of the year in which they attain 19 years of age including natural, adopted and foster children; (3) your unmarried child or children from age 19 up to their 25th birthday who legally reside with you, are wholly dependent upon you for support, are full-time students attending an accredited secondary school, junior college, college or university or a nursing school; and (4) your unmarried children who are physically or mentally incapacitated and who are dependent upon you for support regardless of their age.

For the purpose of this definition, the term "children" includes children born to you, children adopted by you or placed for adoption with you, stepchildren and foster children living with you in a normal parent-child relationship and who are dependent upon you for financial support to the extent they qualify as a Dependent as defined in the Internal Revenue Code. "Placement for adoption" means you have assumed a legal obligation for total or partial support of a child in anticipation of adoption.

CHEMICAL DEPENDENCY means the abuse of, addiction to, or dependency on the use of drugs, narcotics or alcohol.

COSMETIC PROCEDURE means surgical or non-surgical cosmetic procedures which are undertaken primarily to improve or otherwise modify a person's appearance including, but not limited to, surgery to the upper and lower eyelid; penile implant; augmentation mammoplasty or reduction mammoplasty; silicone injections to any part of the body; full or partial face lift; rhinoplasty (nose reconstruction); derma or chemo abrasion; otoplasty (correction of ear deformities or defects); scar revision; and lift, stretch or reduction of abdomen, buttocks, thighs or upper arm.

COVEREDMEDICAL EXPENSE means charges incurred by a covered person which (1) are medically necessary for the care and treatment of sickness or injury; (2) are recommended by a physician; (3) do not exceed the reasonable and customary charges in the area in which the service is rendered and (4) you are legally obligated to pay. Expenses are considered to be incurred on the date service or supplies are rendered or obtained and not on the date of the bill.

DISABILITY means an inability to perform any and every duty of your occupation or employment that results from an injury or disease that was incurred as a compensable injury

or illness under any state workers' compensation law.

ELIGIBLE INDIVIDUAL means you, the Employee, and each of your eligible Dependents, if any, provided that you timely enroll.

An **EMPLOYEE** is (1) an individual who works for a Contributing Employer who is required to make contributions to the Plan on the Employee's behalf; (2) an individual who works in the jurisdiction of a Local Union which has signed a Reciprocal Agreement under this Plan; (3) full-time salaried Corporate Officers; (4) self-employed individuals who have a Collective Bargaining Agreement in effect with the Union; and (5) salaried Union and Association Officers.

INJURY means bodily harm that is caused by an accident.

A **MEDICALLY NECESSARY SERVICE** is a service which is required to identify or treat the illness or injury which a Physician has diagnosed or reasonably suspects. The service must:

- (a) Be consistent with the diagnosis and treatment of your condition;
- (b) Be in accordance with standards of good medical practice;
- (c) Be required for reasons other than your convenience of your Physician's; and
- (d) Be performed in the least costly setting required by your condition.

The fact that a service is prescribed by a Physician does not necessarily mean that service is Medically Necessary.

MEDICARE means the program established under Title XVIII of the Social Security Act (Federal Health Insurance for the Aged) as it is presently in force or amended in the future.

MENTAL OR NERVOUS DISORDER means a mental illness or functional nervous disorder, including a neurosis, psychoneurosis, which is recognized by the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and current as of the date of the relevant diagnosis.

OUTPATIENT SURGICAL CENTER means a Healthcare facility in which surgery is performed on patients on an outpatient basis and which meets the following requirements;

- (a) it must be licensed and supervised by a full-time physician and keep medical records on all patients; (b) it must employ a licensed anesthesiologist and an R.N. and the doctor who performs the surgery must also be allowed operating privileges at a local hospital; and (c) it must have at least two operating rooms and a recovery room, be equipped to take care of emergencies and have an agreement with a local hospital to take patients who develop complications or other difficulties requiring hospital care.

PHYSICIAN means an individual who is operating within the scope of his license and is licensed to prescribe and administer drugs or to perform surgery. Licensed chiropractors, licensed ophthalmologists and licensed nurse-midwives (with respect to maternity care) are included in the definition of Physician. For purposes of the Vision Benefit section of the Plan only, the term “physician” will include a dispensing optician.

PLAN means the Rules and Regulations of the Sheet Metal Workers Local Union No. 32 Health and Welfare Plan, as adopted and amended in the future.

PREFERRED PROVIDER ORGANIZATION (PPO) is the dental plan where you have a choice of how to use your coverage each time you need dental care. If you use providers in the PPO network you receive the highest level of benefits. If you use providers outside of the PPO network, you will be responsible for any charges in excess of the dental schedule.

QUALIFIED MEDICAL SUPPORT ORDER: A judgment or decree order issued by a court of competent jurisdiction or state agency which recognizes your child(ren) as Eligible Dependents. The child who is to be provided coverage is an Alternative Recipient. The order may be in the form of National Medical Child Support Notice and must contain the following:

- (a) The order specifies your name and last known address and the Alternative Recipients’ name and last known address;
- (b) The order provides a description of the coverage to be provided or the manner in which the type of coverage is to be determined;
- (c) The order states the period to which it applies; and
- (d) The order specifies each plan that it applies to.

It is your responsibility to provide a copy of a Medical Child Support Order to the Administrative Manager’s Office. This Order will be reviewed to determine if it meets the requirements to be deemed “Qualified”. If further information is needed, you will be asked to provide such information, at your expense, to the administrative Manager’s Office. The Plan will notify you and the Alternative Recipient of the procedures for determining if the order is qualified. The final decision regarding the qualifications of the Order will be made by the Board of Trustees.

SICKNESS means a disease, disorder or condition which requires treatment by a Physician. Sickness includes childbirth, pregnancy or any related condition.

**IV.
HMO COVERAGE AND EXCLUSIONS**

TYPES OF COVERAGE

This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. More complete descriptions of Benefits and the terms under which they are provided are contained the Certificate of Coverage that you will receive upon enrolling in the Plan.

If this Benefit Summary conflicts in any way with the Contract issued to your Trustees, the Contract shall prevail.

Terms that are capitalized in the Benefit summary are defined in the Certificate of Coverage.

Network health care services under this benefit plan are covered only when provided, arranged or authorized by a Network Physician.

NETWORK BENEFITS/COPAYMENT AMOUNTS

United Healthcare of Florida, Inc. is financially responsible for Network Benefits.

Annual Deductible: No Annual Deductible

Out-of-Pocket Maximum: \$1,000 per Covered Person per calendar year, not to exceed \$2,000 for all Covered Persons in a family. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the HMO's Certificate of Coverage.
Maximum Contract Benefit: No Maximum Policy Benefits

TYPES OF COVERAGE

NETWORK BENEFITS/COPAYMENT AMOUNTS

1. AMBULANCE SERVICES

Emergency Only	Ground Transportation: No Copayment
	Air Transportation: 0% of Eligible Expenses

2. DENTAL SERVICES

Accident Only	*No Copayment
	*Prior notification is required before the follow-up treatment begins

3. DURABLE MEDICAL EQUIPMENT

Benefits for Durable Medical Equipment are limited to \$2,500 per calendar year.	No Copayment
--	--------------

4. EMERGENCY HEALTH SERVICES

\$100 per visit

5. EYE EXAMINATIONS

Refractive eye examinations are limited to one every other calendar year from a Routine Vision Network Provider.	\$20 per visit
--	----------------

6. HOME HEALTH CARE

Benefits are limited to 60 visits for skilled care services per calendar year. No Copayment

7. HOSPICE CARE

Benefits are limited to 360 days during the entire period of time a Covered Person is covered under the Contract. No Copayment

8. HOSPITAL - INPATIENT STAY \$250 per Inpatient Stay

9. INJECTIONS RECEIVED IN A PHYSICIAN'S OFFICE \$20 per payment

10. MATERNITY SERVICES Same as 8, 11, 12 and 13
No Copayment applies to Physician office visits for prenatal care after the first visit.

11. OUTPATIENT SURGERY, DIAGNOSTIC AND THERAPEUTIC SERVICES

Outpatient Surgery No Copayment

Outpatient Diagnostic Services (Lab and Radiology/X-ray) X-ray: For lab and radiology No Copayment

Outpatient Diagnostic/Therapeutic Services (CT Scans, PET Scans, MRJ and Nuclear Medicine) No Copayment

Outpatient Therapeutic Treatments No Copayment

12. PHYSICIAN'S OFFICE SERVICES

Covered Health Services for preventive medical care \$20 per visit
No Copayment applies when a Physician charge is not assessed

Covered Health Services for the diagnosis and treatment of Sickness or Injury received Physician's office \$20 per visit
No Copayment applies a when a Physician in a charge is not assessed

13. PROFESSIONAL FEES FOR SURGICAL AND MEDICAL SERVICES No Copayment

14. PROSTHETIC DEVICES

Except for items required by the Women's Health and Cancer Rights Act of 1998. Benefits for prosthetic devices are limited to \$2,500 per calendar year. No Copayment

15. RECONSTRUCTIVE PROCEDURES Same as 8, 11, 12, 13 and 14

**16. REHABILITATION SERVICES -
OUTPATIENT THERAPY** \$20 per visit

Benefits are limited as follows:
20 visits of physical therapy
20 visits of occupational therapy
20 visits of speech therapy
20 visits of pulmonary rehabilitation; and
36 visits of cardiac rehabilitation per calendar year

**17. SKILLED NURSING FACILITY/INPATIENT
REHABILITATION FACILITY SERVICES** No Copayment

Benefits are limited to 60 days per calendar year

18. TRANSPORTATION SERVICES *Same as 8 and 13

19. URGENT CARE CENTER SERVICES \$50 per visit

ADDITIONAL BENEFITS

TYPES OF COVERAGE

NETWORK BENEFITS/COPAYMENT AMOUNTS

**BONES OR JOINTS OF THE JAW
AND FACIAL REGION** Same as 8, 11, 12 and 13

**CHILD HEALTH SUPERVISION
SERVICES** Same as 11, 12 and 13

**CLEFT LIP/CLEF PALATE
TREATMENT** Same as 8, 11, 12, 13 and 16

**DENTAL PROCEDURES
ANESTHESIA AND
HOSPITALIZATION** Same as 8, 11 and 13

DIABETES TREATMENT Same as 3, 11, 12 and 13

MAMMOGRAPHY No Copayment

MASTECTOMY Same as 3, 11, 12 and 13

**MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
OUTPATIENT** \$20 per individual visit
Must receive prior authorization \$15 per group visit
through the Mental Health/Substance
Abuse Designee. Benefits are limited
to 30 visits per calendar year

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES**INPATIENT AND INTERMEDIATE**

\$250 per

Must receive prior authorization through the Mental Health/Substance Abuse Designee. Benefits are limited to 30 days per calendar year

Inpatient Stay

OSTEOPOROSIS TREATMENT

Same as 11, 12 and 13

PRESCRIPTION AND NON-PRESCRIPTION**ENTEROL FORMULAS**

No Copayment

Benefits are limited to \$2,500 per calendar year.

SPINAL TREATMENT

\$20 per visit

Benefits include diagnosis and related services and are limited to one visit and treatment per day. Benefits are limited to 24 visits per calendar year.

While most pharmacies participate in the network, you should check first. Call your pharmacist or visit the online pharmacy service at www.365WellSt.com. The online service offers you home delivery of prescriptions, ability to view personal benefit coverage, access health and well being information, and even location of network retail neighborhood pharmacies by zip code.

COPAYMENT PER PRESCRIPTION ORDER OR REFILL

For a single Copayment, you may receive Prescription Drug Product up to the stated supply limit, unless it is adjusted based on the drug manufacturer's packaging size, or based on supply limits. Some products are subject to additional supply limits.

Also note that some Prescription Drug Products require that you notify in advance to determine whether the Prescription Drug Product meets the definition of a Covered Health Service and is not Experimental, Investigational or Unproven.

	GENERIC PRESCRIPTION DRUG PRODUCT	BRAND-NAME PRESCRIPTION DRUG PRODUCT ON THE PREFERRED DRUG LIST*	BRAND-NAME PRESCRIPTION DRUG PRODUCT NOT ON THE PREFERRED DRUG LIST*
Retail Network Pharmacy For up to a 31 day supply	\$10	\$30	\$50
Mail Service Network Pharmacy For up to a 90 day supply	\$25	\$75	\$125
Retail Non-Network Pharmacy For up to a 31 day supply	\$10	\$30	\$50

*Our Preferred Drug List includes those drugs available to you at the most affordable cost. It is one of the best ways to maximize your prescription drug benefits. The drug list, developed by physicians and pharmacists on our national Pharmacy and Therapeutics committee, includes a wide selection of generic and brand name prescription medications commonly prescribed by physicians. The Preferred Drug List is updated throughout the year. The most current version is available at our online pharmacy at www.365WellSt.com.

NOTE: ELIGIBLE PERSONS WHO LIVE OUTSIDE THE AREAS OF SERVICE FOR THE HMO NETWORK HAVE A SEPARATE PPO SET OF BENEFITS OUTLINED IN THE CERTIFICATE OF COVERAGE SENT TO YOU OUTLINING PPO PLAN 11.

HMO EXCLUSIONS

Except as may be specifically provided in Section 1 of the Certificate of Coverage (COC) or through a Rider to the Contract, the following are not covered:

A. ALTERNATIVE TREATMENTS

Acupressure; hypnotism; rolfing; massage therapy; aromatherapy; acupuncture; and other forms of alternative treatment.

B. COMFORT OR CONVENIENCE

Personal comfort or convenience items or services such as television; telephone; barber or beauty service; guest service; supplies, equipment and similar incidental services and supplies for personal comfort including air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers and humidifiers; devices or computers to assist in communication and speech.

C. DENTAL *

Except as specifically described as covered in Section 1 of the COC under the heading *Dental Services-Accidental only* and *Cleft Lip/Cleft Palate Treatment*, dental services are excluded. There is no coverage for services provided for the prevention, diagnosis, and treatment of the teeth, or gums (including extraction, restoration, and replacement of teeth, and services to improve dental clinical outcomes).

Dental implants and dental braces are excluded. Dental x-rays, supplies and appliances and all associated expenses arising out of such dental services (including hospitalizations and anesthesia) are excluded, except as might otherwise be required for transplant preparation, initiation of immunosuppressive, or the direct treatment of acute traumatic injury, cancer, cleft palate, or dental care described in Section 1 of the COC under the heading. *Dental Procedures - Anesthesia and Hospitalization.* treatment for congenitally missing, malpositioned, or super numerary teeth is excluded, even if part of Congenital Anomaly except in connection with cleft lip or cleft palate.

D. DRUGS

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications except as described in Section 1 of the COC under the heading *Diabetes Treatment.* Non-injectable medications given in a Physician's office except as required in an Emergency. Over-the-counter drugs and treatments.

E. EXPERIMENTAL, INVESTIGATIONAL OR UNPROVEN SERVICES

Experimental, Investigational or Unproven Services are excluded except (a) bone marrow transplants and (b) medically appropriate medications prescribed for the treatment of cancer, for a particular indication, if that drug is recognized for the treatment of that indication in a standard reference compendium or recommended in the medical literature. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

F. FOOT CARE

Routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting, or debriding; hygienic and preventive maintenance foot care; treatment of flat feet or subluxation of the foot; shoe orthotics.

G. MEDICAL SUPPLIES AND APPLIANCE

Devices used specifically as safety items or to affect performance primarily in sports-related activities. Prescribed or non-prescribed medical supplies and disposable supplies including but not limited to elastic stockings, ace bandages, gauze and dressings, ostomy supplies, syringes except as described under Section 1 of the COC under the heading *Diabetes Treatment.* Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces). Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 1 of the COC.

H. MENTAL HEALTH/SUBSTANCE ABUSE

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Treatment of insomnia and other sleep disorders, dementia, neurological disorders, and other disorders with a known physical basis. Treatment of conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee. Services utilizing methadone treatment as maintenance, L.A.A.M. (l-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee. Residential treatment services. Services or supplies that in the reasonable judgement of the Mental Health/Substance Abuse Designee are not, for example, consistent with certain national standards or professional research further describe in Section 2 of the COC.

I. NUTRITION

Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups, except as described in Section 1 under the heading *Diabetes Treatment*. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk except as described in Section 1 under the heading Prescription and Non-Prescription Enteral Formulas.

J. PHYSICAL APPEARANCE

Cosmetic Procedures including, but not limited to, pharmacological regimens; nutritional procedures or treatments; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne. Replacement of an existing breast implant is excluded if the earlier breast implant was a Cosmetic Procedure. (Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.) Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs for medical and non-medical reasons. Wigs, regardless of the reason for the hair loss.

K. PROVIDERS

Services performed by a provider with your same legal residence or who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services provided at a freestanding or Hospital-based diagnostic facility without an order written by a Physician or other provider as further described in Section 2 of the COC (this exclusion does not apply to mammography testing).

L. REPRODUCTION

Health services and associated expenses for infertility treatments. Surrogate parenting. The reversal of voluntary sterilization.

M. SERVICES PROVIDED UNDER ANOTHER PLAN

Health services for which other coverage is paid under arrangements required by federal, state or local law. This includes but not limited to coverage paid by workers' compensation, no-fault automobile insurance, or similar legislation. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

N. TRANSPLANTS

Health services for organ or tissue transplants are excluded, except those specified as covered in Section 1 of the COC. Any solid organ transplant that is performed as a treatment for cancer.

Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. Health services for transplants involving mechanical or animal organs.

Transplant services that are not performed at a Designated Facility. Any multiple organ transplant not listed as a Covered Health Service in Section 1 of the COC.

O. TRAVEL

Health services provided in a foreign country, unless required as Emergency Health Services.

Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

P. VISION AND HEARING*

Purchase cost of eye glasses, contact lenses, or hearing aids. Fitting charge for hearing aids, eye glasses or contact lenses. Eye exercise therapy. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye strategy.

Q. OTHER EXCLUSIONS

Health services and supplies that do not meet the definition of a Covered Health Service - see definition in Section 10 of the COC.

Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments otherwise covered under the Contract, when such services are: (1) required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) to obtain or maintain a license of any type. Health services received as a result of war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country.

Health services received after the date your coverage under Contract ends, including health services for medical conditions arising prior to the date your coverage under the Contract ends.

Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Contract. Charges in excess of Eligible Expenses or in excess of any specified limitation.

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature except as described in Section 1 of the COC under the heading *Bones or Joints of the Jaw and Facial Region*. Surgical treatment and non-surgical treatment of obesity (including morbid obesity).

Growth hormone therapy; sex transformation operations; treatment of benign gynecomastia (abnormal breast enlargement in males); medical and surgical treatment of excessive sweating (hyperhidrosis); medical and surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea. Oral appliances for snoring. Custodial care; domiciliary care; private duty nursing; respite care; rest cures. Psychosurgery. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from injury, stroke, cleft lip/cleft palate or Congenital Anomaly.

*Basic Dental and Vision Benefits are provided directly from the Fund as shown on page 64 of this booklet.

V.
SELF-FUNDED BENEFITS
(Dental and Vision)

Dental Panel

The Plan has contracted with certain dentists known as “Panel Providers” to provide dental services. In order to limit your out-of-pocket expenses under the schedule, you must use one of the following dental providers for your dental care:

Randy Freedline, D.D.S.
2627 NE 203rd Street, Suite 212
Aventura, Florida 33180
(305) 932-9202

Albert Ziemba, D.D.S.
7500 NW 5th Street, Suite 108
Plantation, Florida 33317
(954) 581-7540

Michael Westcott, D.D.S.
3111 45th Street, Suite 7
West Palm Beach, Florida 33407
(561) 687-0006

Lawrence Rosen, D.D.S.
2926 Jog Road
Greenacres, Florida 33467
(561) 965-3066

Description of Dental Benefits

The Plan will pay a percentage of covered dental expenses you incur, up to the maximum allowable fees of the Plan as stated in the Dental Schedule.

Calendar Year Limit

Each Covered Person is subject to the limits for dental benefits payable under the Plan for each calendar year as shown in the Schedule of Benefits.

No Annual Deductible

There is no Annual Deductible which must be met before dental benefits become payable.

Treatment Categories and Percentages

The percentage of covered dental expenses reimbursed depends in part on the type of dental treatment you receive. Diagnostic and preventive treatments are covered at 100% for both panel and non-panel providers, “restorative” treatments are covered at 80% for both panel and non-panel providers and “major” dental treatments are covered at 80% for both panel providers and non-panel providers. Below is a representative (not all-inclusive) listing of the types of treatments included in these three categories.

Diagnostic and Preventive (100% Reimbursement of Schedule)

This Category includes:

- (a) Routine oral examination and prophylaxis (cleaning and scaling of teeth), limited to once each in any period of 180 consecutive days.
- (b) Topical application of sodium fluoride and stannous fluoride.
- (c) Dental X-rays, including full-mouth X-rays (limited to once in any period of 36 consecutive months) supplementary bitewing X-rays (limited to once in any period of 180 consecutive days) and such other dental X-rays as are required in connection with the diagnosis of a specific condition requiring treatment.

Restorative (80% Reimbursement of Schedule)

This Category includes fillings, root canals, periodontics treatment, extractions, oral surgery, amalgam filling restorations, crowns, repair or cementing of crowns, inlays, onlays and repair of bridgework or dentures.

Major (80%) Reimbursement of Schedule

This Category includes initial installation of fixed bridgework, initial installation of partial or full removable dentures.

It also includes replacement of an existing removable denture by new denture, replacement of fixed bridgework by new bridgework and the addition of new teeth to an existing partial removable denture or to bridgework, but only if certain preconditions are met. Information concerning these conditions is available from the Fund Office.

Dental Exclusions and Limitations

No payment will be made under the Plan for the following:

- (a) Treatment by someone other than a licensed dentist, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of a dentist.
- (b) The replacement of a lost, missing or stolen prosthetic device, except as provided herein.
- (c) Treatment of conditions related to the temporomandibular jaw joint (TMJ).
- (d) Treatment provided as a result of dental disease, defect or injury due to war, declared or undeclared or any act of war or aggression.
- (e) Treatment resulting from any occupational injury or sickness, whether or not covered by a Workers' Compensation Law or similar law.
- (f) Any Dental treatment which begins while a person is not eligible for Dental Expense Benefits or prosthetic devices (including bridges and crowns) and the fitting of such devices, which are ordered while the person is not eligible

for Dental Expense Benefits. Treatment is considered to being: (i) for full or partial dentures when the impression is taken for the appliances: (ii) for fillings, bridgework, crowns or other gold restorations, when the tooth is first prepared; and (iii) for root canal therapy, when the tooth is opened. If your eligibility for dental Expense Benefits is terminated, Dental Coverage will be extended solely for purposes of completing the above described treatments, for a period not exceeding 90 days after the above-beginning dates.

	ELIGIBLE CHARGES	BENEFITS	OUT-OF POCKET
CLINICAL ORAL EXAMS			
120 Periodic Oral Examination	\$ 40.00	\$ 40.00	
130 Limited Oral Evaluation- Problem Focused	75.00	75.00	
150 Comprehensive Oral Evaluation	75.00	75.00	
160 Detailed and Extensive Oral Evaluation-Problem Focused by Report	100.00	100.00	
RADIOGRAPHS			
210 Intraoral-Complete Series (including bitewings)	90.00	90.00	
220 Intraoral-Periapical-First Film	20.00	20.00	
230 Intraoral-Periapical Each Additional Film	16.00	16.00	
270 Bitewings/Single Film	22.00	22.00	
272 Bitewings/Two Films	45.00	45.00	
274 Bitewings/Four Films	55.00	55.00	
TEST AND LABORATORY EXAMINATIONS			
460 Pulp Vitality Tests	50.00	40.00	10.00
DENTAL PROPHYLAXIS			
1110 Prophylaxis Adult	60.00	60.00	
1120 Prophylaxis Child	48.00	48.00	
TOPICAL FLUORIDE TREATMENTS			
1203 Topical Application of Fluoride (prophylaxis not included) – Child	60.00	60.00	
1204 Topical Application of Fluoride (prophylaxis not included) – Adult	48.00	48.00	
OTHER PREVENTATIVE SERVICES			
1351 Sealant – Per Tooth	40.00	32.00	8.00
SPACE MAINTENANCE			
1510 Space Maintainer – Fixed Unilateral	300.00	240.00	60.00
1515 Space Maintainer – Fixed Bilateral	450.00	360.00	90.00
1550 Recementation of Space Maintainer	75.00	60.00	15.00
AMALGAM RESTORATIONS			
2140 Amalgam – One Surface/Permanent	90.00	72.00	18.00
2150 Amalgam – Two Surfaces/Permanent	120.00	96.00	24.00
2160 Amalgam – Three Surfaces/Permanent	150.00	120.00	30.00
2161 Amalgam – Four or More Surfaces/Permanent	180.00	144.00	36.00
RESIN RESTORATIONS			
2330 Resin – One Surface, Anterior	115.00	92.00	23.00
2331 Resin – Two Surfaces, Anterior	150.00	120.00	30.00
2332 Resin – Three Surfaces, Anterior	185.00	148.00	37.00
2335 Resin – Four or More Surfaces or Involving Incisal	230.00	184.00	46.00
2391 Resin – One Surface, Posterior-Permanent	125.00	100.00	25.00
2392 Resin – Two Surfaces, Posterior-Permanent	170.00	136.00	34.00
2383 Resin – Three or More Surfaces, Posterior-Permanent	230.00	184.00	46.00

CROWNS

2740 Crown – Porcelain/Ceramic Substrate	775.00	620.00	155.00
2750 Crown – Porcelain Fused to High Noble Metal	775.00	620.00	155.00
2790 Crown – Full Crown Cast Noble Metal	775.00	620.00	155.00

OTHER RESTORATIVE SERVICES

2910 Recement Inlay	80.00	64.00	16.00
2920 Recement Crown	80.00	64.00	16.00
2940 Sedative Filling	80.00	64.00	16.00
2950 Crown Buildup, Including any Pins	225.00	180.00	45.00
2952 Cast Post and Core in Addition to Crown	375.00	300.00	75.00
2954 Prefabricated Post and Core in Addition to Crown	275.00	220.00	55.00
2970 Temporary Crown (fractured tooth)	230.00	184.00	46.00
2980 Crown Repair, By Report	230.00	184.00	46.00

PULP CAPPING

3110 Pulp Cap-Direct (excluding final restoration)	60.00	48.00	12.00
3120 Pulp Cap-Indirect (excluding final restoration)	70.00	56.00	14.00

PULPOTOMY

3220 Therapeutic Pulpotomy (excluding final restoration)	210.00	168.00	42.00
---	--------	--------	-------

**ROOT CANAL THERAPY INCLUDES TREATMENT
CLINICAL PROCEDURES AND FOLLOW-UP CARE**

3310 Root Canal-Anterior (excluding final restoration)	450.00	360.00	90.00
3320 Root Canal-Bicuspid (excluding final restoration)	550.00	440.00	110.00
3330 Root Canal-Molar (excluding final restoration)	650.00	520.00	130.00
3346 Retreatment of Previous Root Canal Therapy-Anterior	500.00	400.00	100.00
3347 Retreatment of Previous Root Canal Therapy-Bicuspid	600.00	480.00	120.00
3348 Retreatment of Previous Root Canal Therapy – Molar	700.00	560.00	140.00

PERIAPICAL SERVICES

3410 Apicoectomy/Periradicular Surgery-Anterior	430.00	344.00	86.00
3450 Root Amputation – Per Root	400.00	320.00	80.00

OTHER ENDODONTIC PROCEDURES

3920 Hemisection (including any root removal), not including RCT	360.00	288.00	72.00
---	--------	--------	-------

**PERIODONTIC-INCLUDING USUAL
POSTOPERATIVE SERVICES**

4211 Gingivectomy or Gingivoplasty Per Tooth	150.00	120.00	30.00
---	--------	--------	-------

ADJUNCTIVE PERIODONTAL SERVICES

4321 Provisional Splinting – Extracoronal	400.00	320.00	80.00
4341 Periodontal Scaling and Root Planing-Per Quadrant	180.00	144.00	36.00

OTHER PERIODONTAL SERVICES

4910 Periodontal Maintenance Procedures-Prophylaxis (following active therapy)	56.00	45.00	11.00
---	-------	-------	-------

PROSTHODONTIC-COMPLETE DENTURES

5110 Complete Denture-Maxillary	950.00	760.00	190.00
5120 Complete Denture-Mandibular	950.00	760.00	190.00
5130 Immediate Denture-Maxillary	950.00	760.00	190.00
5140 Immediate Denture-Mandibular	950.00	760.00	190.00

PROSTHODONTIC – PARTIAL DENTURES**(including Any Conventional Clasps and Rests)**

5211 Maxillary Partial Denture – Resin Base	650.00	520.00	130.00
5212 Mandibular Partial Denture – Resin Base	650.00	520.00	130.00
5213 Maxillary Partial Denture- Cast Metal Framework Resin Base	1100.00	880.00	220.00
5214 Mandibular Partial Denture- Cast Metal Framework Resin Base	1100.00	880.00	220.00
5281 Unilateral Metal Partial Denture	800.00	640.00	160.00

ADJUSTMENT TO DENTURES

5410 Adjust Complete Denture-Maxillary	70.00	56.00	14.00
5411 Adjust Complete Denture-Mandibular	70.00	56.00	14.00
5421 Adjust Partial Denture-Maxillary	70.00	56.00	14.00
5422 Adjust Partial Denture-Mandibular	70.00	56.00	14.00

REPAIRS TO COMPLETE DENTURES

5510 Repair Broken Complete Denture Base	175.00	140.00	35.00
5520 Replaced Missing or Broken Teeth Complete Denture-Each Tooth	150.00	120.00	30.00

REPAIRS TO PARTIAL DENTURES

5610 Repair Resin Denture Base	150.00	120.00	30.00
5620 Repair Cast Framework	215.00	172.00	43.00
5630 Repair or Replace Broken Clasp	185.00	148.00	37.00
5640 Replace Broken Teeth – per Tooth	150.00	120.00	30.00
5650 Adding Tooth to Existing Partial Denture	185.00	148.00	37.00
5660 Add Clasp to Existing Partial Denture	225.00	180.00	45.00

DENTURE RELINE

5730 Reline Complete Maxillary Denture (chairside)	260.00	208.00	52.00
5731 Reline Complete Mandibular Denture (chairside)	260.00	208.00	52.00
5740 Reline Maxillary Partial Denture (chairside)	260.00	208.00	52.00
5741 Reline Mandibular Partial Denture (chairside)	260.00	208.00	52.00
5750 Reline Complete Maxillary Denture (laboratory)	360.00	288.00	72.00
5751 Reline Complete Mandibular Denture (laboratory)	360.00	288.00	72.00
5760 Reline Maxillary Partial Denture (laboratory)	360.00	288.00	72.00
5761 Reline Mandibular Partial Denture (laboratory)	360.00	288.00	72.00

OTHER REMOVABLE PROSTHETIC SERVICES

5850 Tissue Conditioning, Maxillary	180.00	144.00	36.00
5851 Tissue Conditioning, Mandibular	180.00	144.00	36.00
5988 Surgical Stent	275.00	220.00	55.00

PROSTHODONTICS – FIXED PONTICS

6210 Pontic – Cast High Noble Metal	675.00	540.00	135.00
6240 Pontic – Porcelain Fused to High Noble Metal	675.00	540.00	135.00

PROSTHODONTICS – FIXED ABUTMENTS

6750 Crown – Porcelain Fused to High Noble Metal	650.00	520.00	130.00
6790 Crown – Full Cast High Noble Metal	650.00	520.00	130.00

OTHER FIXED PROSTHETIC SERVICES

6730 Recement Fixed Partial Denture	125.00	100.00	25.00
-------------------------------------	--------	--------	-------

EXTRACTIONS

7110 Extraction – Single Tooth	112.00	90.00	22.00
7120 Extraction – Each Additional Tooth	112.00	90.00	22.00
7130 Extraction – Root Removal – Exposed Roots	165.00	132.00	33.00

SURGICAL EXTRACTIONS

7210 Surgical Removal of Erupted Tooth Requiring Flap with Bone Removal	225.00	180.00	45.00
7220 Removal of Impacted Tooth – Soft Tissue	265.00	212.00	53.00
7250 Surgical Removal of Residual Roots (cutting procedure)	210.00	168.00	42.00

OTHER SURGICAL PROCEDURES

7310 Alveoplasty in Conjunction with Extractions	265.00	212.00	53.00
7510 Incision and Drainage of Abscess – Intraoral Soft Tissue	175.00	140.00	35.00

OTHER REPAIR PROCEDURES

7960 Frenulectomy (Frenectomy or Frenotomy) Separate Procedure	360.00	288.00	72.00
---	--------	--------	-------

UNCLASSIFIED TREATMENT

9110 Palliative (emergency) treatment of Dental Pain	98.00	79.00	19.00
---	-------	-------	-------

PROFESSIONAL VISITS

9430 Office Visit for Observation (regularly scheduled)	60.00	48.00	12.00
9340 Office Visit – After Regularly Scheduled Hours	125.00	100.00	25.00

MISCELLANEOUS SERVICES

9910 Application of Desensitizing Medicament	85.00	68.00	17.00
9940 Occlusal Guard, By Report	490.00	392.00	98.00
9951 Occlusal Adjustment – Limited	175.00	140.00	35.00

Out-of-Pocket may increase if you go to a Non-PPO dentist, but in no event will the Plan pay in excess of those amounts under the “Benefits” column in the above Schedule.

VISION CARE BENEFIT

The Plan will pay Vision Care Benefits to a Covered Person for Vision Care charges incurred for supplies and services furnished while covered under the Plan.

VISION CARE BENEFIT PERIOD. Vision Care Benefit Periods begin on each January 1st and end on the next following December 31.

VI. GENERAL INFORMATION

COORDINATION OF BENEFITS

(a) When the other group plan does not contain a coordination of Benefits provision, that plan is considered primary and will pay first, regardless of the coverage provided by that plan. This Plan is considered secondary and will then pay toward the remaining covered expenses.

(b) When the other group plan contains a Coordination of Benefits provision, the order of benefits will be determined as follows:

(1) The group plan covering the patient as an employee is primary and pays before the group plan covering the patient as a dependent.

(2) The benefits of a plan which covers the patient as an employee who is neither laid off nor retired are determined before the benefits of a plan which covers that person as a laid-off or retired employee.

(3) The group plan covering the patient as a dependent of a parent whose birthday (excluding year of birth) falls earlier in the calendar year is primary and pays before the group plan of the parent whose birthday (excluding year of birth) falls later in the calendar year.

(4) In situations of divorce, separation and/or divorce and remarriage, benefits for a child's medical expenses will be payable as follows:

(i) In case of divorce or separation, the group plan which is primary shifts from that of the natural father to the household where the child resides. This means that if the child lives with the natural mother, her plan pays first and if the child lives with the natural father, his plan pays first.

(ii) If the parent with whom the child resides remarries, the order of benefit is as follows:

- Natural parent with whom child resides,
- Step-parent with whom child resides,
- Natural parent not having custody of child.

(iii) The order of benefit determination can change if there is a divorce decree requiring one of the parents to be financially responsible for benefits provided by this Plan.

In that case:

- The Plan of the parent with court-ordered financial responsibility pays first.
- The plan of the other natural parent pays second, and
- The plan covering the spouse of the parent with court-ordered financial responsibility pays third.

(c) When the other group plans do not contain the rule in subsection (b) (2), the group plan covering the patient as a dependent of a male (father) is primary and pays before the group plan covering the patient as a dependent of a female (mother).

(d) If none of the above rules apply, the Plan which has covered the patient for the longer period of time will pay its benefits first.

SUBROGATION (DENTAL AND VISION ONLY)

Subrogation seeks to conserve the assets of the Plan by imposing the expense for accidental injuries to you or your Eligible Dependents on those responsible for causing them. For example, if you or one of your Dependents should receive benefits from the Plan for injuries caused by someone else, the Plan, through subrogation, has the right to seek repayment from the other party or his insurance company. Or in the event you or your Dependent (or your guardian or estate) recover the amount of medical expense paid by the Plan by suit, settlement or otherwise from any third person or his insurer, the Plan has the right to be reimbursed through subrogation, before any attorneys fees or other costs are deducted from the settlement or other payment). In addition, this Plan will be subrogated for attorney's fees incurred in enforcing its subrogation rights.

The Plan will provide benefits to you and your Eligible Dependents at the time of need, but you will be required to sign a Subrogation Agreement or other documents or take such other action as is necessary to assure the rights of the Plan. You must promptly notify the Plan of any claim or legal action which you or your Dependents assert against any party or insurance carrier for injuries which you or a Dependent sustains. Subrogation does not apply to an individual health policy which you purchase for yourself or your Dependents.

In the event the Plan is not reimbursed for benefits paid to you, when a settlement is obtained for medical expenses incurred, the Plan will withhold payment on future claims for expenses you incur, until the full amount has been recouped by the Plan.

MEDICARE

Medicare refers to the federal government's insurance plan that was created by Title XVIII of the Social Security Act of 1965 and which has undergone several amendments since that time. There are two parts to Medicare. The part which pays for hospital bills is called "Part A." The part which pays for doctor bills and other medical care expenses is called "Part B."

Because Medicare is actually administered by the Social Security Administration of the federal government, this booklet should not be considered your only source of information about Medicare. For descriptive booklets and other information about all aspects of the Medicare program, contact the Social Security Administration. Their telephone number and nearest office address can be found in the white pages of your telephone directory.

Generally, Medicare is available to the following groups of people:

(a) All persons, age 65 and over, who are also eligible for Social Security benefits or Railroad Retirement Act benefits.

(b) Certain other persons, age 65 and over, that are not eligible for Social Security or Railroad Retirement benefits but who are resident citizens can enroll in Medicare by paying the necessary Medicare premiums.

(c) Certain persons, regardless of age, who become disabled or who have a kidney condition that can be classified as "End Stage Renal Disease."

The federal government makes no monthly premium charge for a person enrolled in Medicare's Part A (except for people in category (b) above). There is a premium charge for Medicare's Part B. It varies each year and the Social Security Administration can tell you the current amount of that premium and it can also advise you how it can be paid.

Persons who are eligible for Medicare and wish to enroll must contact their nearest Social Security Administration office within three months prior to the time they are first eligible to enroll which, for most persons, is age 65.

As long as you remain actively employed and eligible under this Plan, all benefits provided under the Plan will remain fully in force, whether or not you are eligible for the health benefits provided by the Medicare Program.

TIME OF PAYMENTS OF BENEFITS

Benefits will be paid as assigned after the Administrative Manager/HMO Administrator receives your completed claim form. Do not wait until you return to work before making a claim for benefits – do it immediately. It is your responsibility to provide the adequate information to process your claim.

NOTICE OF CLAIM

Claim must be filed with the Fund office or HMO within 90 days after the occurrence of the event on which the claim is based. Written notice given by or on behalf of the Eligible Individual to the Plan with particulars sufficient to identify the Eligible Individual will be considered notice to the Plan. Failure to file your claim or give written notice within the 90-day time period will neither invalidate nor reduce any claim if you can show that it was reasonably possible to give written notice within that time and that written notice was given as soon as reasonably possible.

HOW TO FILE A CLAIM

In order to receive the fastest possible service, all dental and vision claims should be reported to the Fund Office as soon as possible. The Administrative Manager's Office will furnish you with the claim forms necessary for filing a claim. The name and address of the Administrative Manager is shown elsewhere in this booklet. HMO claims will generally be filed direct with the HMO by the Service Provider.

OTHER PROVISIONS

ALTERED OR FORGED CLAIMS

Any claim form submitted by or on behalf of an Eligible Individual that contains a material alteration or forged information will be rejected by the Plan, which reserves the right to forward the altered or forged document to the local law enforcement agency for whatever legal action such agency deems to be appropriate.

PERSONS TO WHOM BENEFITS ARE PAYABLE

If you want to assign your benefits when permitted, the check will be sent directly to the provider instead of to you. To assign benefits, complete the assignment section of the claim form or special forms your Healthcare provider will provide.

PLEASE REPORT CHANGES PROMPTLY

IT IS IMPORTANT TO NOTIFY THE ADMINISTRATIVE MANAGER AND THE HMO WHENEVER

- (a) you acquire a new Dependent; or
- (b) an existing Dependent is no longer eligible (limiting age, etc.); or
- (c) you change your home address;
- (d) you change your beneficiary for life insurance benefits; if any;
- (e) you enter the armed forces; or
- (f) you go on a leave of absence for any reason.

If you or your covered Dependent (spouse or child) fails to give proper notice of his/her change of address, age,

marital, dependent or disability status within 60 days, and as a result the Plan pays a claim for a person whose coverage should have been terminated, then the person who signed the Election Form and the person who failed to give the required notice will both be obligated to reimburse the Plan in full for any claims which should not have been paid. If the Plan does not receive full reimbursement, then all amounts due may be deducted from other benefits otherwise payable on behalf of the person who signed the Election Forms, the person who failed to give the required notice and their Covered Dependents, whether or not benefits have been assigned.

FACILITY OF PAYMENT OF BENEFITS

If an individual is a minor or otherwise not competent to give a valid receipt of any benefit due him and if no request for payment has been received by the Plan from a duly appointed guardian or other legally appointed representative of the individual, the Plan will make direct payment to the individual or institution appearing to the Plan to have assumed the custody of or the principal support of the individual.

If an individual dies while benefits for services remain unpaid, the Plan will make direct payment to the individual or institution on whose charges claim is based or to any of the following surviving relatives of the individual: wife or husband, mother and/or father, child or children, brothers and/or sisters, or to your executors or administrators.

Any payment by the Plan in accordance with this section will discharge the obligation of the Plan to the extent of the payment made.

PHYSICAL EXAMINATION

The Plan at its own expense will have the right and opportunity, while a claim is pending, to examine any individual whose Injury or Sickness is the basis of claim when and so often as it may reasonably require and to make an autopsy in the case of death where it is not prohibited by law.

TIME LIMITATIONS

If at any time limitations set forth in the Plan for giving notice of claims or for furnishing proof of loss is less than permitted by the law of the state in which the Eligible Individual resides at the time benefits are in effect, then the time limitation will be amended to conform with the minimum requirements by the law of that state.

PHYSICIAN-PATIENT RELATIONSHIP

As part of the Plan's managed care strategies, your choice of doctors and other providers depends on how you use your benefit plan. Otherwise, there is no disturbance in the Physician-patient relationship.

ASSIGNMENT

The benefits provided by the Plan are not assignable, except as previously stated.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

The Plan and HMO may release to, or obtain from any company, organization or person, without consent of or notice to any person, any information regarding any person which the Plan deems necessary to carry out this provision or like terms of any Plan, or to determine how or if they apply. Any claimant under this Plan will furnish to the Plan any information as may be necessary to implement this provision.

RIGHT OF RECOVERY

If the Plan paid more than it should have, the Plan has the right to recover the excess amount. This can be from the person for whom the payments were made. It can also be from any other insurance company, service provider or organization.

LEGAL ACTION

No action at law or in equity will be brought to recover on any benefits prior to the claimant's exhaustion of the Claims Review Procedure previously described.

CONSTRUCTION

All questions of interpretation of this Plan are decided by the Trustees under the express authority granted to them by the Agreement and Declaration of Trust. The Trustees shall be the sole arbiter of questions of eligibility and amounts of benefits. This Plan is intended to comply with the terms and conditions of the Agreement and Declaration of Trust. If a decision of the Trustees or those acting for the Trustees is challenged in court, then such decision will be upheld unless it is determined to be arbitrary and capricious.

VII. CLAIMS PROCEDURE AND REVIEW OF CLAIMS

Claim Procedures

(1) Claims shall be reviewed and a decision rendered thereupon as follows:

(a) **Generally:** Except as otherwise provided herein, if a claim is wholly or partially denied, the Board of Trustees shall notify the Covered Employee or Dependent of the Board's adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the Board, unless the Board determines that special circumstances require an extension of time for processing the claim. If the Board determines that an extension of time for processing is required, written notice of the extension shall be furnished to the Covered Employee or Dependent prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Board expects to render the benefit determination.

(i) **Urgent Care claims:** In the case of a claim involving urgent care, the Board of Trustees shall notify the Covered Employee or Dependent of the Board's determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Board of Trustees shall notify the Covered Employee or Dependent as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The Covered Employee or Dependent shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any adverse benefit determination pursuant to this paragraph shall be made in accordance with this section. The Board of Trustees shall notify the Covered Employee or Dependent of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of (i) the Plan's receipt of the specified information or (ii) the end of the period afforded the Covered Employee or Dependent to provide the specified additional information.

(ii) **Concurrent care claims:** If the Board of Trustees has approved an ongoing course of treatment to be provided over a period of time or number of treatments, then any reduction or termination by the Board of Trustees of such course of treatment (other than by plan amendment or

termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The Board of Trustees shall notify the Covered Employee or Dependent, in accordance with this section, of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. Any request by a claimant to extend the course of Treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies and the Board of Trustees shall notify the Covered Employee or Dependent of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Board of Trustees, provided that any such claim is made to the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with section and appeal shall be governed by as set forth herein.

(iii) **Pre-service claims:** In the case of a pre-service claim, the Board of Trustees shall notify the Covered Employee or Dependent of the Board's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim of the Plan. This period may be extended one time by the Board of Trustees, for up to 15 days, provided that the Board both determines that such an extension is necessary due to matters beyond the control of the Board and notifies the Covered Employee or Dependent, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Board expects to render a decision. If such an extension is necessary due to a failure of the Covered Employee or Dependent to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information and the Covered Employee or Dependent shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. Notification of any adverse benefit determination pursuant to this paragraph shall be made in accordance with this Section

(iv) **Post-service claims:** In the case of a post-service claim, the Board of Trustees shall notify the Covered Employee or Dependent of the Board's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Board of Trustees, for up to 15 days, provided that the Board of Trustees both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the

Covered Employee or Dependent, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Board expects to render a decision. If such an extension is necessary due to a failure of the Covered Employee or Dependent to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information and the Covered Employee or Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(v) **Disability claims:** In the case of a claim for disability benefits, the Board of Trustees shall notify the claimant, in accordance with this section, of the Board's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan. This period may be extended by the Board for up to 30 days, provided that the Board both determines that such an extension is necessary due to matters beyond the control of the Board and notifies the Covered Employee or Dependent, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If, prior to the end of the first 30-day extension period, the Board determines that, due to matters beyond the control of the Board, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Board notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Board expects to render a decision. In the case of any extension under this paragraph, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues and the Covered Employee or Dependent shall be afforded at least 45 days within which to provide the specified information.

(2) **Calculating time periods:** The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted pursuant to this section due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(3) Manner and content of notification of benefit determination:

Except as provided otherwise herein, the Board of Trustees shall provide the Covered Employee or Dependent with written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i),(iii) and (iv). In the case of a claim regarding urgent care, notification pursuant to this provision may be given orally within the time frame prescribed above, provided that a written or electronic notification is furnished not later than 3 days following the date of oral notification. The notification shall set forth, in a manner calculated to be understood by the claimant:

(i) The specific reason or reasons for the adverse determination;

(ii) Reference to the specific plan provisions on which the determination is based;

(iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.

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

(v) In the case of an adverse benefit determination relating to disability benefits, if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to the claimant upon request; or if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances or a statement that such explanation will be provided free of charge upon request.

(vi) In the case of an adverse benefit determination relating to a claim involving urgent care, a description of the expedited review process to such claims.

(4) Failure to File Properly: In the case of a failure by a Covered Employee or Dependent or an authorized representative of a Covered Employee or Dependent to follow the procedures set forth herein for filing a pre-service claim, the Covered Employee or Dependent, or his authorized representative, shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. Said notification shall be provided as soon as possible, but not later than 5 days (24 hours in the case of a failure to file a claim involving urgent care) following the failure. Notification may be oral, unless written notification is requested by the Covered Employee or Dependent, or his authorized agent.

Review of Claims (Appeals Procedure)

(1) Generally: Any Dependent or Covered Employee who applies for benefits under the Plan and is ruled ineligible or not qualified or who believe he did not receive the full amount of benefits to which he is entitled or who is otherwise adversely affected by any action of the Trustees shall have the right to a full and fair review of said claim by the Board of Trustees, provided that he makes such a request in writing within one hundred eighty (180) days from the date upon which the Covered Employee or Dependent received the notice of the adverse determination. The Covered Employee or Dependent has the right to submit written comments, documents, records and other information relating to the claim for benefits and shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits. The review shall take into account all comments, documents, records and other information submitted by the Covered Employee or Dependent relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. Additionally, the review shall

(a) not afford deference to the initial adverse benefit determination and shall not be conducted by any individual who made the adverse benefit determination that is the subject of the appeal nor the subordinate of such individual:

(b) with respect to any adverse determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, include consultation by the Board with a Healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual who has consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

(c) include disclosure to the Covered Employee or Dependent the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

(d) in the case of a claim involving urgent care, include an expedited review process pursuant to which a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant and all necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile or other available similarly expeditious method.

(2) **Time Period for Determination:** Except as provided specifically below, the Board shall make a determination upon review no later than the date of the meeting of the Board that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the Board following the Plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Board shall provide the Covered Employee or Dependent with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Board of Trustees shall notify the Covered Employee or Dependent of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(a) **Urgent Care Claims:** In the case of a claim involving urgent care, the Board of Trustees shall notify the Covered Employee or Dependent of the Board's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the request for review of an adverse benefit determination by the Plan.

(b) **Pre-Service Claims:** In the case of a pre-service claim, the Board shall notify the claimant of the Board's decision upon review within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt by the Plan of the claimant's request for review of an adverse benefit determination.

(3) Calculating Time Periods: For purposes of this Section, the period of time within which a benefit determination on review is required to be made shall begin at the time a request for an appeal is received by the Board of Trustees, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted above due to the failure of the Covered Employee or Dependent to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(4) Manner and content of notification of benefit determination on review: The Board of Trustees shall provide the Covered Employee or Dependent with written or electronic notification of the Board's decision of the claim upon review. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii) and (iv). In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant:

(a) The specific reason or reasons for the adverse determination;

(b) Reference to the specific plan provisions on which the benefit determination is based;

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

(d) A statement of the claimant's right to bring an action under section 502(a) of the Act; and

(e) In the case of disability benefits, if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion; or a statement that such rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the Covered Employee or Dependent upon request;

(f) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances or a statement that such explanation will be provided free of charge upon request; and

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

Definitions applicable to this section.

For the purposes of this Article, the following terms shall have the meaning ascribed below:

(1) A “**claim involving urgent care**” is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations –

(i) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or

(ii) In the opinion of a physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The determination of whether a claim is a “claim involving urgent care” is to be made by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, except that any claim that a physician with knowledge of the claimant’s medical condition determines is a “claim involving urgent care” shall be treated as a “claim involving urgent care” for purposes of this section.

(2) The term “**pre-service claim**” means any claim for a benefit with respect to which the receipt of the benefit, in whole or in part, is conditioned upon the approval of the benefit in advance of obtaining medical care.

(3) The term “**post-service claim**” means any claim for a benefit that is not a pre-service claim.

(4) The term “**adverse benefit determination**” means any of the following: a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a Covered Employee’s or Dependent’s eligibility to participate in a plan and including a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(5) The term “**notice**” or “**notification**” means the delivery or furnishing of information in a manner that satisfies the standards of 29 CFR 2520.1045b-1(b) as appropriate with respect to material required to be furnished or made available.

(6) The term “**healthcare professional**” means a physician or other healthcare professional licensed, accredited or certified to perform specified health services consistent with State law.

(7) A document, record or other information shall be considered “**relevant**” to a Covered Employee’s or Dependent’s claim if such document, record or other information, (i) was relied upon in making the benefit determination, (ii) was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination, (iii) demonstrates compliance with the administrative processes and safeguards required pursuant to this section in making the benefit determination, or (iv) in the case of disability benefits, constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant’s diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

VIII. HIPPA RIGHTS, PRIVACY AND SECURITY PROVISIONS

T

he Plan may use your Protected Health Information (“PHI”), as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 (“HIPPA”), for purposes of making or obtaining payment for your care and for conducting health care operations. The Plan has established a policy to safeguard your PHI from unnecessary use and disclosure.

Following is a summary of the permitted uses and disclosures of your PHI.

• **To Make or Obtain Payment**

The Plan may use your PHI to make payment or to collect payment from third parties such as other health plans or providers for the care you receive. For example, the Plan may provide information regarding your coverage or treatment to other Health Plans in order to coordinate payment of benefits.

• **To Conduct Healthcare Operations**

The Plan may use or disclose health information as necessary to provide coverage and services to all of the Plan’s Participants and for its own Operations such as:

- Quality Assessment
- Customer Service
- Review and Auditing
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits
- Business management and general administrative activities of the Plan.

For example, information concerning your eligibility and benefits may be disclosed to provider’s offices inquiring about your plan prior to rendering services to you.

• **When Legally Required**

The Plan will disclose your PHI when it is required to do so by any federal, state or local law.

• **To Conduct Health Oversight Activities**

The Plan may disclose your PHI to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The Plan may not disclose your PHI if you are the subject of an investigation which is not directly related to your receipt of healthcare or public benefits.

- **In Connection with Judicial and Administrative Proceedings**

As permitted or required by state law, the Plan may disclose your PHI in the course of any judicial or administrative proceeding in response to an order of a court of subpoena, discovery request or other lawful process, but only when the Plan makes reasonable efforts to either notify you about the request or to obtain an order protecting your PHI.

- **For Law Enforcement Purposes**

As permitted or required by state law, the Plan may disclose your PHI to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Plan has suspicion that your death was the result of criminal conduct, or in an emergency to report a crime.

- **In the Event of Serious Health or Safety Threats**

In accordance with applicable law and ethical standards of conduct, the Plan may disclose your health information in the event that it, in good faith, believes that such disclosure is necessary to lessen or prevent a serious and imminent threat to your health and safety or that of the public.

- **For Specified Government Functions**

In certain circumstances, federal regulations require the Plan to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the President and others and correctional institutions and inmates.

- **For Worker's Compensation**

The Plan may release your PHI to the extent necessary to comply with Worker's Compensation or similar program laws.

Other than as stated above, the Plan will not disclose your health information without your written authorization. If you authorize the Plan to use or disclose your health information for purposes other than those defined above, you may revoke that authorization in writing at any time.

Participant Rights Concerning Protected Health Information

You have the following rights regarding your health information that the Plan maintains:

- **Right to Request Restrictions**

You may request restrictions on certain uses and disclosures of your PHI. You have the right to request a limit on the Plan's disclosure of your PHI to someone involved in the payment of your care. However, the Plan is not required to agree to your request. In the event that you wish to request such a restriction, please make your request in writing to the designated contact person listed on the last page of this notice.

- **Right to Receive Confidential Communications**

You have the right to request that the Plan communications with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may request that the Plan only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing to the designated contact person listed on the last page of this notice. The Plan will make every effort to honor your reasonable request for confidential communications.

- **Right to Inspect and Copy your Health Information**

You have the right to inspect and copy your PHI. A request to inspect and copy records containing your PHI must be made in writing to the designated contact person listed on the last page of this notice.

If you request a copy of your health information, the Plan may charge a reasonable fee for the copying, assembling and, if applicable, postage associated with your request.

- **Right to Amend your Health Information**

If you believe that your PHI records are inaccurate or incomplete, you may request that the Plan amend your records. That request may be made as long as the information is maintained by the Plan. A request for an amendment of records must be made in writing to the designated contact person listed on the last page of this notice.

The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the Plan, if the health information you wish to amend falls within an exception to the PHI you are permitted to inspect and copy, or if the Plan determines the records containing your PHI are accurate and complete.

- **Right to an Accounting**

You have the right to request a list of certain disclosures of your health information that the Plan is required to keep under the Privacy Rule, such as disclosures for public purposes authorized by law or disclosures that are not in accordance with the Plan's privacy policies and applicable law. The request must be in writing to the contact person listed on the last page of this notice.

The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting request may not be made for periods of time going back more than six (6) years. The Plan will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Plan will inform you in advance of the fee, if applicable.

• **Right to a Paper Copy of the Plan's Notice of Privacy Practices**

You have the right to request and receive a paper copy of this Notice at any time. To obtain a paper copy, please contact the designated individual listed on the last page of this notice.

• **Disclosure of PHI**

The Trustees have taken great care to ensure that your PHI is kept confidential and secure. However, your PHI may be released to the Trustees, Fund Manager, Fund Consultant, and Fringe Benefit Coordinator to the extent necessary for them to perform their administrative functions. Any person who uses or discloses PHI in violation of the Plan's privacy policies and procedures or in violation of Plan provision shall be subject to the Plan's privacy disciplinary procedure.

Security of Electronic Private Health Information

It is the intent and purpose of the Plan to implement the provisions of the Health Insurance Portability and Accountability Act and the regulations promulgated hereunder, relating to the safeguarding of electronic Protected Health Information (PHI).

• **Requirements**

Should the Plan create, receive, maintain or transmit any electronic Protected Health Information, the Fund shall:

(1) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI created, received, maintained or transmitted on behalf of the Plan; and

(2) Ensure that the adequate separation required is supported by reasonable and appropriate security measures; and

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

(4) Report appropriately any security incident of which it becomes aware; and

(5) The Plan has implemented reasonable and appropriate written policies and procedures to comply with the regulations and maintain a written record of any action, activity or assessment required by said regulations. The Plan may change said policies and procedures at any time, provided that any such changes are documented and implemented in accordance with the regulations. All documentation required by the Act shall be retained for a minimum of 6 years following the date of its creation or the date upon which it was last in effect, whichever is later, and shall be made available to all persons responsible for implementing the procedures to which such documentation pertains. The Trustees shall review such documentation periodically, and update same as needed, in response to environmental or operational changes affecting the security

of the electronic Protected Health Information.

- **Business Associate Contracts**

The Plan shall, effective as of April 20, 2005, maintain Business Associate Contracts, within the meaning of the Act, with all of its Business Associates, which contracts shall provide for the safeguards of electronic Protected Health Information, as set forth in the regulations.

- **Contact Person**

The Health Plan has designated William A. Rhodes, Jr., Privacy Officer, as its contact person for all issues regarding patient privacy and your privacy rights. You may contact this person as follows:

P.O. Box 721380
Houston, Texas 77272-1380
Tel: (866) 521-7632

XII.
STATEMENT OF RIGHTS UNDER
THE EMPLOYEE RETIREMENT
INCOME SECURITY ACT OF 1974 (ERISA)

As a participant in the SHEET METAL WORKERS LOCAL UNION NO. 32 HEALTH AND WELFARE PLAN, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants are entitled to:

1. RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine, without charge, at the Administrative Manager's office all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, a list of the employers and employee organizations participating in the Plan and a copy of the latest Annual Report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Administrative Manager, copies of all documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, copies of the latest Annual Report (Form 5500 series) and an updated Summary Plan Description and a list of the employers and employee organizations participating in the Plan. The Administrative Manager may make a reasonable charge for the copies. It is suggested you contact the Administrative Manager to determine the cost prior to requesting any copies.

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

2. CONTINUE GROUP HEALTH COVERAGE

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 and your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

A Reduction or elimination of exclusionary periods of coverage for pre-existing 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, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be

subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

3. 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 Plan. These people are referred to as “fiduciaries” in the law. Fiduciaries must act solely in the interest of the Plan Participants and they must exercise prudence in the performance of their Plan duties. Fiduciaries who violate ERISA may be removed and required to make good any losses they may have caused the Plan.

Your employer and union may not fire you or discriminate against you to prevent you from obtaining a welfare benefit from the Plan or exercising your rights under ERISA.

4. ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents on the latest Annual Report from the Plan and do not receive them within 30 days, you may file suit in a Federal Court. In that case, the Court may require the administrative Manager 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 Administrative Manager. If you have a claim for benefits that is wholly or partly denied, you may file suit in a state or federal court, but only after you have appealed the denial pursuant to the Plan’s claims review and appeal procedure. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal Court. If it should happen that Plan fiduciaries misuse the Plan’s money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suite 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 are unsuccessful in your lawsuit, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

5. ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Administrative Manager. If you have any questions about this Statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Administrative Manager, you should contact the

nearest office of the Pension and Welfare Benefits Administration, United States Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 publication hotline of the Pension and Welfare Benefits Administration.

The foregoing has been no more than a brief and very general description of the most important provisions of the Plan. If there are any discrepancies between the information contained in this booklet and the actual Plan Document and Trust Agreement, the provisions of the Plan Document will govern. No description such as this can adequately express all the details of the Plan. Should you have any question, which is not covered by this booklet, please contact the Administrative Manager for an answer.

X.
SCHEDULE OF BENEFITS
AS OF JANUARY 1, 2008

HEALTH CARE BENEFITS

Medical Health Care Benefits are provided through United Health Plans

VISION CARE BENEFITS

Vision Care Benefits are self-funded and the schedule relating to the reimbursement of Vision Care Benefits is as follows:

Individual Calendar Year Maximum	\$300.00
Family Calendar Year Maximum	\$900.00

There are no exceptions or limitations. The covered participant and qualified dependents can obtain any type of Vision Care treatment and supplies up to the maximum limits set forth above.

DENTAL CARE BENEFITS

Family Maximum is limited to \$2,000 per Calendar year. Benefits are reimbursed in accordance with the attached Schedule of Eligible Charges.

PERCENTAGE THAT PLAN PAYS

Type 1 Expense-Diagnostic and Preventive	-100%-
Type 2 Expense-Restorative e.g. Fillings, Crowns, Root Canals, etc.	-80%-
Type 3 Expense-Major e.g. dentures, bridgework, etc.	-80%-