SHEET METAL WORKERS LOCAL NO. 33 YOUNGSTOWN DISTRICT HEALTH & WELFARE FUND

SUMMARY PLAN DESCRIPTION

EFFECTIVE DATE
July 1, 2009

July 1, 2009

Dear Participant:

We are pleased to distribute this revised Summary Plan Description (SPD) detailing the benefits provided under the Sheet Metal Workers Local No. 33 Youngstown District Health & Welfare Fund. This SPD replaces and supersedes in its entirety your previous Summary Plan Description.

This SPD summarizes the eligibility rules for participation in the Plan, the benefits provided to those who are eligible, and the procedures which must be followed when applying for a benefit. In addition, in this SPD is important information concerning the administration of the Plan and your rights as a Participant.

Since there have been many Plan changes, please take the time to read this SPD and make yourself and your family familiar with the Plan benefits.

If you have any questions concerning your eligibility, the benefits provided or the general provisions of the Plan, please contact the Fund Office. Please also note that the receipt of this booklet does not infer that you are eligible for benefits. Your eligibility will be determined by the Plan's Rules of Eligibility which are set forth in this SPD.

Sincerely,

THE BOARD OF TRUSTEES

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ADDITIONAL INFORMATION REQUIRED BY ERISA

Plan Name:	Sheet Metal Workers Local No. 33 Youngstown District Health and Welfare Fund
Plan Sponsor:	Board of Trustees Sheet Metal Workers Local No. 33 Youngstown District
Tax I.D. Number:	34-6751847
Administrative Manager	Compensation Programs of Ohio, Inc. 33 Fitch Boulevard Austintown, Ohio 44515 1-800-733-7709
Type of Plan:	Group Insurance Plan
Plan Year Ends:	December 31
Statutory Agent for Service of Legal Process:	Dennis Haines, Esq. Green, Haines, Sgambati, Co., LPA National City Bank Building, Suite 400 P. O. Box 849 Youngstown, Ohio 44501-0849

Service of legal process may also be made upon a Plan Trustee or the Administrative Manager

Board of Trustees

MANAGEMENT TRUSTEES	LABOR TRUSTEES
Mr. Michael Fagert	Mr. Tim Dwyer
Mr. Kevin Reilly	Mr. Rob Bodnar
Mr. Jim Thornton	Mr. David Patton

I. MEDICAL SCHEDULE OF BENEFITS

FOR ELIGIBLE EMPLOYEES (Includes Eligible Retirees under Age 65, unless otherwise indicated)

	In-Network benefits*	**Out-of-Network benefits***
General Plan Provisions		
Annual Deductibles	$400 Single $800 Family	$800 Single $1,600 Family
Co-Insurance	80%	70%
Annual out-of-pocket limit (includes deductible)	$1,500 Single $3,000 Family	$3,000 Single $6,000 Family
Maximum lifetime benefit per individual	$1,000,000	
Dependent Age Limit	19 for dependents unless dependent is full-time student, then up to age 25	
Preventive Care		
Physician Office Visit (including routine physical, mammogram, hearing tests, and PAP)	100% of covered expenses up to $150 per person maximum per calendar year (not subject to deductibles)	
Well-baby, child care, immunizations up to age 9	The Plan pays 80% after deductible	The Plan pays 70% after deductible
Physician's Services		
Second and Third surgical opinions	The Plan pays 80% after deductible	The Plan pays 70% after deductible
Surgery	The Plan pays 80% after deductible	The Plan pays 70% after deductible
Allergy Testing	The Plan pays 80% after deductible	The Plan pays 70% after deductible
Allergy Injections	The Plan pays 80% after deductible	The Plan pays 70% after deductible
Emergency Services: accident related	The Plan pays 80% After In-Network Deductible	
Non-emergency accident/illness	The Plan pays 80% after deductible	The Plan pays 70% after deductible
Diagnostic tests	The Plan pays 80% after deductible	The Plan pays 70% after deductible
Diagnostic x-ray	The Plan pays 80% after deductible	The Plan pays 70% after deductible
Anesthesia	The Plan pays 80% after deductible	The Plan pays 70% after deductible

*See page 3

	In-Network benefits*	Out-of-Network benefits*
Physical Therapy[1]	The Plan pays 80% after deductible	The Plan pays 70% after deductible
Chiropractic Services[2]	The Plan pays 80% after deductible	The Plan pays 70% after deductible
Inpatient medical care visits	The Plan pays 80% after deductible	The Plan pays 70% after deductible
Maternity Care		
Physician care and delivery	The Plan pays 80% after deductible	The Plan pays 70% after deductible
Initial Newborn Exam[3]	The Plan pays 80% after deductible	The Plan pays 70% after deductible
Hospital Services[3]	The Plan pays 80% after deductible	The Plan pays 70% after deductible
Abortion Services	The Plan pays 80% after deductible	The Plan pays 70% after deductible
Hospital Services		
Pre-admission testing	The Plan pays 80% after deductible	The Plan pays 70% after deductible
Post-discharge testing	The Plan pays 80% after deductible	The Plan pays 70% after deductible
Organ transplant (heart, heat-lung, kidney, liver, pancreas)	The Plan pays 80% after deductible	The Plan pays 70% after deductible
Emergency Services; Accident related	The Plan pays 80%	
Non-emergency accident/illness	The Plan pays 80% after deductible	The Plan pays 70% after deductible
Physical Therapy[1]	The Plan pays 80% after deductible	The Plan pays 70% after deductible
Hospice Care		
Up to six months of life expectancy	100% up to $5,000 inpatient care 30 days (including respite care)	
Mental Health and Nervous Disorders		
Inpatient coverage	The Plan pays 80% after deductible	The Plan pays 70% after deductible
Outpatient coverage[4]	The Plan pays 80% after deductible	The Plan pays 70% after deductible

[1]Treatments will be reviewed for medical necessity

[2]Spinal manipulations limited to $1,000 per calendar year per person

[3]Benefits not provided for dependent's children

[4]Treatments are limited to 12 visits per calendar year, combined with any physician services

*See page 3

	In-Network benefits*	Out-of-Network benefits*
Drug and alcohol abuse treatment		
Inpatient coverage[5]	The Plan pays 80% after deductible	The Plan pays 70% after deductible
Outpatient coverage	The Plan pays 50% after deductible up to $1,000	The Plan pays 50% after deductible up to $1,000
Other Services		
Ambulance	The Plan pays 80% after deductible	
Durable medical equipment[6]	The Plan pays 80% after deductible	The Plan pays 70% after deductible
Skilled Nursing Facility	The Plan pays 80% after deductible	The Plan pays 70% after deductible
Home Health Care[7]	The Plan pays 80% after deductible	The Plan pays 70% after deductible
Private Duty Nursing	The Plan pays 80% after deductible	The Plan pays 70% after deductible
Speech therapy[1]	The Plan pays 80% after deductible	The Plan pays 70% after deductible
Chemotherapy	The Plan pays 80% after deductible	The Plan pays 70% after deductible
Podiatry	The Plan pays 80% after deductible	The Plan pays 70% after deductible

[5]Limited to 30 days per calendar year

[6]Rentals limited to purchase price of equipment

[7] limited to $10,000 per calendar year

***In-Network and Out-of-Network Benefits are reimbursed based upon PPO contractual obligations and no benefits are paid for services over UCR.**

II SUPPLEMENTAL SCHEDULE OF BENEFITS

	Eligible Employees	Eligible Retirees Under Age 65	Eligible Retirees Over Age 65
Life Insurance Benefits			
Coverage	Eligible Participant Only	Eligible Participant Only	Eligible Participant Only
Amount	$6,000.00	$1,500.00[1]	$1,500.00[2]
Accidental Death & Dismemberment Benefits			
Coverage	Eligible Participant Only	Not Available	Not Available
Accidental Death Amount	$6,000.00	Not Available	Not Available
Loss of Both Hands	$6,000.00	Not Available	Not Available
Loss of Both Feet	$6,000.00	Not Available	Not Available
Loss of Both Eyes	$6,000.00	Not Available	Not Available
Loss of One Hand and One Foot	$6,000.00	Not Available	Not Available
Loss of One Hand and One Eye	$6,000.00	Not Available	Not Available
Loss of One Foot and One Eye	$6,000.00	Not Available	Not Available
Loss of One Hand	$3,000.00	Not Available	Not Available
Loss of One Foot	$3,000.00	Not Available	Not Available
Loss of One Eye	$3,000.00	Not Available	Not Available
Weekly Sickness Benefits			
Maximum Weekly Benefit Amount (Net Benefit)	$300.00 per week	Not Available	Not Available
Maximum Duration	26 weeks	Not Available	Not Available
Vision Care Benefits[3]	$250 charges @ 80% $200 maximum per person per calendar year		Not Available
Dental Care Benefits[3] (subject to annual review) See page 35 and Appendix I	$1,000 charges @ 80% $800 maximum per family per calendar year		Not Available

[1]If Retiree is under the age of 65 and eligible for but not participating in the pre-retirement funding program, benefit increases to $6,500.00

[2]Retiree must have been an active participant in the Fund immediately preceding his/her retirement date

[3]Vision Care Benefits and Dental Care Benefits are not subject to the Plan's Medical deductible

	Eligible Employees	Eligible Retirees Under Age 65	Eligible Retirees Over Age 65
Prescription Drug Benefits	See Table Below		Not Available

	RETAIL PROGRAM	MAIL SERVICE PROGRAM[4]
When to Use it	For immediate drug needs or short-term medications	For maintenance or long-term medications
You Pay	• 10% with minimum of $10 for each generic prescription • 25% with a minimum of $25 for each brand name[5] prescription	• 10% with minimum of $10 for each generic prescription • 25% with a minimum of $25 for each brand name[5] prescription
Days Supply Limit	30-day supply or 100 units, whichever is greater	90-day supply
Fill Limit	3 fills allowed on maintenance medications only	None
Annual Maximum	$25,000 per person per calendar year	
Exclusions	See page 33 for exclusions to prescription drugs	
CareMark Customer Service	1-888-202-1654 or www.caremark.com	

[4]You have the option of getting your long-term medications, in a 90-day supply, at either a CVS/pharmacy or through CVS Caremark Mail Service Pharmacy. Your co-pay will be the same for either option.

[5]When a generic is available, but the pharmacy dispenses the brand name medicine for any reason other than physician indicates "dispense as written," you will pay the difference between the brand name drug and the generic plus the brand co-payment

III. YOUR RESPONSIBILITIES AS A PARTICIPANT

**** SPECIAL NOTE ****

This SPD also operates as the Plan Document. Therefore, any reference to one is reference to the other.

The primary purpose of this Plan is to pay benefits to all those who are entitled to benefits. However, in order for the Trustees and the Fund Office staff to achieve this objective, we need your cooperation. There are certain responsibilities which you, as a Participant, must assume. Failure to carry out these responsibilities could affect your eligibility or the benefits payable. A list of your responsibilities under the Plan follows. As you review this list, you will notice that none of these responsibilities is extremely burdensome. In fact, just a little time and effort on your part will aid in protecting your best interests in the Plan.

1. **Take Time to Read this SPD**

This SPD is the primary source of information. This SPD contains information you need to know about how to qualify for benefits, the benefits which are available and how to file a claim for benefits. We have tried to organize the booklet into sections dealing with specific aspects of the Plan and have tried to simplify the language, where possible.

REMEMBER: You owe it to yourself and your family to become familiar with the details of this SPD which provides that information. Of course, if you have any questions that are not answered in the SPD, be sure to contact the Fund Office.

2. **If You Have Not Filed an Enrollment Card -- Do it Now!**

When you first became eligible for benefits under the Plan, you should have received enrollment cards for you to complete and return to the Fund Office. These cards request certain basic information needed for your records in the Fund Office, such as: your Social Security Number, Address, Birth Date, Name and age of Dependents and Name of Beneficiary. This information is vital. Without it, the Fund Office will have difficulty keeping you informed about Plan changes (if your correct address is not on file), and you run the risk of not having a permanent record of your participation under the Plan. So, if you have not yet completed an enrollment card, do it now! Complete a new card if there has been any change in address, beneficiary, or dependent status since you first filed an enrollment card. If you are not sure whether you have filed these cards with the Fund Office, please contact the Fund Office staff. The staff will advise you whether or not your card is on file. If not, a card will be sent for your completion.

3. **Notify the Fund Office Promptly Regarding Any Change in Address, Beneficiary or Dependents**

When there are Plan changes or benefit improvements, we advise you by first class mail. This means that in order to get in touch with you, we must have your current address. So, if you move, make sure the Fund Office has your new address.

Also, if your marital status changes, or if for some other reason, you wish to change the name of your beneficiary, do not forget to send the change in writing to the Fund Office. Unless you do, the latest enrollment card which we have on file will determine who receives any benefit which may be payable in the event of your death. Failure to

change your beneficiary, even when you intend to, is often just an oversight, but such an oversight could be costly to your survivors.

Finally, if you add any dependents to your household, the Fund Office should be notified regarding the name and age of the new dependent(s). Since the Plan does provide certain benefits for dependents, the Fund Office must know who your dependents are. Additionally, if you have a Dependent over age nineteen (19) who is a full time student, you must inform the Fund Office if your Dependent withdrawals from school or upon his or her graduation.

4. Your Claims Payment Obligation

Deductibles: A deductible is the amount of covered medical expenses that you are required to pay each Calendar Year before benefits are paid by the Plan. A family deductible can be satisfied through any combination of individual deductibles. Deductibles are specified in the Schedule of Benefits. See Section I.

Co-Insurance: A payment that represents the portion of the allowed amount that you are responsible to pay after you have met your deductible. The covered services which require a coinsurance payment are specified in the Schedule of Benefits. See Section I.

Lifetime Maximums: The Plan has established an overall lifetime maximum for all benefits for you and for each Covered Dependent, as specified in the Schedule of Benefits. See Section I. Whenever benefits are paid, they are charged against the individual's overall lifetime maximum.

Annual Maximum Benefit: The Plan has established an annual maximum benefit on certain benefits for you and for each Covered Dependent, as specified in the Schedule of Benefits. See Section I. Whenever benefits are paid, they are charged against the individual's annual maximum benefit.

Deductible Carryover: The Plan also contains a deductible carryover feature. This provision states that any expenses applied against your deductible in the last three months of a Calendar Year, will also be applied against your deductibles for the next Calendar Year.

Usual, Customary and Reasonable Charges: This term is commonly called UCR, and refers to the prevailing or normal fees payable to a healthcare provider in a particular geographic area.

For In-Network Providers and Physicians, charges for medical services are established between the Claims Payor and the service provider. The Fund pays these charges at the established rate, so an In-Network doctor or hospital will not bill you for any charges that are above the contracted amount. To verify whether a doctor or hospital participates, you may use the directory, contact Medical Mutual at 1-800-601-9208, visit the Website at www.supermednetwork.com, or ask the medical provider.

For Out-of-Network Providers and Physicians, charges above UCR will not be covered by the Plan. You will be responsible for the charges exceeding UCR due to the fact that the Claims Payor does not have a contract with the Out-of-Network Provider.

With regard to Out-of-Network Hospitals, many of these hospitals still have negotiated payment terms and methods with your Claims Payor in order to establish payment that will be accepted based upon the medical service you receive, so UCR does not technically apply to a hospital.

For example, if an Out-of-Network provider charges a fee of $125.00 for an office visit and the Usual, Reasonable and Customary charge for this visit in the same area is $100.00, you will be responsible for the following payment assuming the deductible is met:

	In-Network Plan pay 80% after deductible	Out-of-Network Plan pay 70% after deductible
Doctor's Office Visit Charge	$125.00	$125.00
UCR amount	$100.00	$100.00
Total Outstanding Amount	$25.00 (provider writes off)	$25.00 (Provider balance bills)
Plan's Payment	$80.00	$70.00
Member's Payment	$20.00 (co-insurance)	$55.00 ($30.00 co-insurance plus $25.00 balance bill amount)

Out-of-Pocket Expense Limit: The Out-of-Pocket expense limit applies to covered benefits and eligible charges of providers and physicians such as deductibles and coinsurance payments. These unpaid expenses are your responsibility until the annual out-of-pocket maximum limit is reached as specified in the Schedule of Benefits. See Section I.

5. **How to Receive Benefits**

A claim must be filed for you to receive benefits. Claim forms and instructions can be obtained from the Fund Office depending upon the benefit. The procedures to be followed to receive a specific benefit are set forth in Filing for Payment of Your Benefits on page 42. It is very important that you follow the established procedures in order to assure that your benefits are paid in a timely manner.

6. **Medical Examination**

No medical examination is required of any Eligible Participant or Eligible Dependent to become initially covered in the Plan. However, the Trustees have the right, through a physician, to examine you or your Dependents as often as they may reasonably require during the pendency of a claim. Additionally, the Trustees have the right and opportunity to require an autopsy in the case of death where it is not otherwise prohibited by law.

IV. GENERAL INFORMATION

1. The Trustees Interpret the Plan

Only the Board of Trustees has the power to interpret and construe the Plan, determine all questions of eligibility and status under the Plan and determine all questions arising in the administration of the Plan, including the power to determine the rights of eligibility of employees, participants, and their dependents and beneficiaries, and to make factual determinations. No union or management representative, individual Trustee, business representative or other individual has the authority to answer questions or make decisions concerning the provisions of the Plan unless such individual has been given that authority by the Board of Trustees and is acting on their behalf. However, the Board of Trustees has authorized the Administrative Manager and their staff to handle routine requests from Participants regarding eligibility rules, benefits and claims procedures. If there are questions involving interpretation of any Plan provisions, the Administrative Manager will ask the Board of Trustees for the final determination.

2. Benefits Are Not Guaranteed; The Plan Can Be Changed

Benefits offered by the Plan are not guaranteed to the Eligible Participants and/or their Eligible Dependents, and the Board of Trustees reserves the right to make any changes to the benefits which the Fund currently provides.

Although the Trustees hope to maintain the present level of benefits and to improve upon them if possible, a primary concern of the Trustees is to protect the financial soundness of the Plan at all times. To achieve this goal may require Plan changes from time to time.

3. Right of Recovery

If we pay more for Covered Services than the provisions of this Plan requires, we have the right to recover the excess from anyone to or for whom the payment was made. The Participant agrees to do whatever is necessary to secure our right to recover the excess payment.

4. Subrogation

The Sheet Metal Workers Local No. 33 Youngstown District Health & Welfare Fund will take advantage of its right to subrogation if you or your dependent is paid benefits by the Plan due to any injury or illness which arises out of the acts or omissions of any person or entity or which arise under any no-fault coverage (for the purpose of this provision, collectively referred to as "Other Coverage"), or medical payment coverage.

The term Covered Person as used hereinafter shall include the employee, participant, or any eligible dependent as defined elsewhere in the Plan.

Subrogation. In the event of any payment under the Plan, the Plan shall, to the extent of such payment, be subrogated to all the rights of recovery of a Covered Person which arise out of the acts or omissions of any person or entity or which arise under any no-fault coverage or any uninsured or underinsured coverage (for the purpose of this provision, collectively referred to as "Other Coverage"). The Plan is subrogated to all rights of recovery of a Covered Person regardless of whether the Covered Person obtains a full or partial recovery from such person, entity or Other Coverage. The Plan's subrogation interest shall take priority over any and all rights of recovery held by a Covered Person against such person, entity, or Other Coverage arising out of the event which triggered the Plan's payment of Medical Benefits. The Plan's subrogation interest shall apply regardless of whether the Covered Person has been or will be made whole and regardless of whether the Covered Person has incurred fees or costs in order to

obtain a recovery from any person, entity, or Other Coverage. The "make-whole" rule shall not apply.

In the event the Plan has a subrogated interest or right of recovery, no Covered Person shall release any party, person, corporation, entity, insurance company, insurance policies, or funds that may be liable or obligated to the Covered Person for the acts or omissions of any person or entity without the written approval of the Plan.

In the event a Covered Person pursues a claim against any person, entity, or Other Coverage, the Covered Person agrees to include the Plan's subrogated interest and rights of recovery in that claim, and if there is a failure to do so, the Plan shall be legally presumed to be included in such claim. In the event a Covered Person does not pursue a claim against any person, entity, or Other Coverage, the Plan shall have the right to pursue, sue, compromise, or settle any such claims in the Covered Person's name and to execute any and all documents necessary to pursue said claim in the Covered Person's name.

Reimbursement. Each Covered Person hereby agrees to reimburse the Plan, for any Medical Benefits paid by the Plan, out of any money recovered from any person, entity, or Other Coverage as the result of judgment, settlement, or otherwise, regardless of how the money is classified. The Plan has the right to be reimbursed in an amount equal to the amount of Medical Benefits paid hereunder, regardless of whether the Covered Person obtains a full or partial recovery from such person, entity or Other Coverage. The Plan shall be reimbursed on a first priority basis, regardless of whether or not the Covered Person has been or will be made whole and regardless of whether the Covered Person has incurred fees or costs in order to obtain a recovery from any person, entity, or Other Coverage. The "make-whole" rule shall not apply.

In the event a Covered Person settles, recovers, or is reimbursed by any person, entity, or Other Coverage, the Covered Person shall hold any such money in trust for the benefit of the Plan. If a Covered Person fails to reimburse the Plan in accordance with this provision, the Covered Person shall be liable to the Plan for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person. Each Covered Person also agrees to execute and deliver all necessary instruments, to furnish such information and assistance, and to take any action the Plan Sponsor may require to facilitate enforcement of its rights under this Plan.

The Plan will not pay or be responsible for, without the written consent of the Plan Sponsor, any fees or costs associated with a Covered Person pursuing a claim against a third party or any other coverage. The Plan's subrogation interest and the Plan's reimbursement interest shall not be subject to offset for any fees or costs associated with a Covered Person pursuing a claim against a third party or any other coverage.

For purposes of this provision, the term "Covered Person" includes anyone acting for, or on behalf of, a Covered Person when the Covered Person is referred to as taking an action.

You are also advised that when you or your eligible Dependents submit a claim to this Plan for injury or illness, you will be required to complete and execute a form requesting the following information:

1. How the injury or illness occurred.
2. The identity of any potentially responsible third parties, including their insurer, adjuster, and claim numbers.
3. Accident reports.
4. An assignment of your beneficial interest in any monetary recovery as a result of such injury or illness, to the extent of the Plan's subrogated interest.

You may also be required to sign other documents and do whatever is reasonably necessary to secure this Plan's Right of Subrogation. The Plan is entitled to full reimbursement prior to any other disbursement of any recovery, including fees and/or expenses.

You or your eligible Dependent shall not do anything to impair or negate this Plan's Right of Subrogation. If you or your eligible Dependent(s) perform any act or fail to act, and such should compromise the Plan's Right of Subrogation in full, this Plan will immediately seek reimbursement of all benefit amounts paid in that regard either by legal action or otherwise.

Furthermore, the Plan shall have the right to offset any future benefit payments to either you or your eligible Dependent(s) in the amount of any outstanding lien.

The Plan may recover mistaken payments in any other lawful manner, as well.

5. **Limitation of Actions**
No legal action may be taken to recover benefits until all claim appeals have been exhausted. No such action may be taken later than three (3) years after expiration of the time within which proof of loss is required.

6. **Your Plan is Tax Exempt**
Your Welfare Plan is classified by the Internal Revenue Service as a 501(c)(9) Trust. This means that the Employer's contribution to the Trust are tax deductible and are not included as part of your income. Also, in most cases, the benefit paid on behalf are not taxable as personal income. Additionally, investments earnings on Plan assets are excluded as taxable income of the Trust since they are specifically set aside for the purpose of providing benefits to Participants and their Eligible Dependents. Such tax exemption works to the benefit of both the Employer and the Employee, in effect, it means that the money which otherwise might be payable as taxes can be used to purchase benefits and to cover administrative expenses. The Trustees are well aware of these advantages and will take whatever measures are necessary to keep your Plan qualified as a tax-exempt trust under Internal Revenue Services rules.

7. **In the Event of Plan Termination**
In the event the Plan, in the opinion of the Trustee, is inadequate to carry out the intent and purpose under the Agreement and Declaration of Trust, or to meet the payments due or to become due to Participant, the Plan may be terminated by the Trustees. Upon termination of the Plan, providing there are funds remaining, the Trustees shall:

(1) Make provisions for the payment of all expenses, debts and obligations incurred by the Trustees;

(2) Arrange for a final audit and report of the Trustees' transactions and accounts for the purpose of termination of the Trustees' trusteeship;

(3) Reduce all assets to cash and apply the funds first to the payment of all debts and outstanding obligations of the Trust and Plan, and distribute the balance to such Funds or Charities as determined by the Trustees in the exercise of their best discretion.

8. **About Your Plan**

The Sheet Metal Workers Local No. 33 Youngstown District Health & Welfare Fund is maintained as a result of a Collective Bargaining Agreement between your Employer and the Union. Decisions on Plan operations and benefits are made by the Board of Trustees on which labor and management are equally represented. Working together, the Board of Trustees establishes rules of eligibility, strives constantly to improve benefits, supervise the investments of the Fund's money and sees that the Fund is in compliance with all applicable federal and state laws. In carrying out these responsibilities, the Trustees are assisted by a team of professionals, including:

The Administrative Manager who handles the day-to-day business activities of the Fund, such as keeping the records of money received, crediting each Participant's account with the correct contributions received, payment of medical bills, and answering Inquires from participants about their eligibility and benefits.

The Fund Attorney advises the Trustees about what must be done to assure that all operations of the Fund comply with federal and state laws.

The Fund Consultant who assists the Trustees in determining the level of benefits which can be provided from Fund resources and advises the Trustees on many other matters important to the Fund's operations.

9. **Gender**

In the construction of this SPD, the masculine shall also include the feminine and the use of singular will also include the plural where required in order to be appropriate for your situation.

V. RULES OF ELIGIBILITY -- ELIGIBLE EMPLOYEE

NOTE: It will be the responsibility of each Participant to ascertain his own eligibility status and any notification of impending loss of eligibility will be considered a courtesy to the Participant.

1. INITIAL ELIGIBILITY

If you are employed in a class of eligible employees, you will become eligible for benefits on the first day of the month following the work month in which you accumulate a total of 320 hours of employment with one or more contributing Employers within a period of nine (9) consecutive months or less, and contributions are received by the Fund for those hours. An eligible employee may elect to prepay the amount of the contributions required to become Initially Eligible.

Once you have become eligible, you will remain eligible for the balance of the benefit quarter during which you became eligible and the subsequent benefit quarter. Thereafter, you will have to satisfy the requirements for continuation of eligibility. Benefit quarters are discussed in Continuation of Eligibility below.

The eligibility rules are illustrated by the following table:

MONTH IN WHICH YOU SATISFIED THE ***320*** HOUR ACCUMULATION	ELIGIBILITY EFFECTIVE	WILL REMAIN ELIGIBLE THROUGH
January	February 1	June 30
February	March 1	September 30
March	April 1	September 30
April	May 1	September 30
May	June 1	December 31
June	July 1	December 31
July	August 1	December 31
August	September 1	March 31
September	October 1	March 31
October	November 1	March 31
November	December 1	June 30
December	January 1	June 30

2. CONTINUATION OF ELIGIBILITY

Beyond your initial eligibility periods, you will remain eligible provided you are credited with at least 400 hours of employment in the appropriate eligibility quarter. The eligibility quarters and corresponding benefit quarters are as follows:

Eligibility Quarters	Hours Worked	Work Months
July, Aug. and Sept.	400	Jan., Feb. and March
Oct., Nov. and Dec.	400	April, May and June
Jan., Feb. and March	400	July, Aug. and Sept.
April, May and June	400	Oct., Nov. and Dec.

3. HOUR BANK PLAN

You can accumulate paid-up eligibility to be used during periods of low or no employment through the hour bank plan. The hour bank plan is a system under which credit is accumulated based upon hours reported on your behalf by your employer.

Additions to your "account" will be made for contributions received in excess of 425 hours during any eligibility quarter; up to a maximum accumulation of 1,600 hours. For any eligibility quarter in which credited hours are less than 425, the number of hours needed to total 400 will be deducted from the balance, if any.

Except as provided in the rules dealing with military service, any remaining balance will be eliminated on the date your coverage terminates or at the end of a benefit quarter in which you have become no longer regularly available for employment in the jurisdiction of Local Union 33 - Youngstown District.

The hour bank is not a vested benefit of the employee. The Trustees reserve the right to adjust the hour bank based upon changes in costs and, if conditions so warrant, to eliminate the hour bank provision in its entirety. The hour bank will be used only for the purpose of continuing eligibility and in no event will any balance in an employee's hour bank be returned directly to the participant except as provided in the rules dealing with retirement.

If you are called up for active duty in the armed services, you are entitled to the protection of the Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA). The Fund will allow you the choice of using your Hour Bank to continue coverage for you and/or your dependents or freezing your Hour Bank until your reinstatement in the Plan. The provisions for reinstatement are based on your application for re-employment and will vary depending on your length of stay in the uniformed services. You need to contact the Fund Office to discuss your options to continue coverage for you and your dependents. In most instances, when you are called to active duty, coverage is provided to you through the military which offers several plans to persons on active duty and, under certain conditions, his/her dependents.

It is extremely important, if you wish to have a continuation of benefits under USERRA, that immediately upon learning of your armed service related absence for any period, you discuss your options with the Fund Office.

4. TERMINATION OF ELIGIBILITY

If you have not met the minimum hours requirement as stated above to continue eligibility and you do not have a sufficient balance in your hour bank to achieve the

minimum requirement, your eligibility for benefits will terminate unless a self payment is made to continue benefit eligibility as explained below.

5. SELF-CONTRIBUTIONS

(1) Once your Hour Bank is insufficient or exhausted, you are still entitled to preserve eligibility, other than through Reinstatement of Eligibility, by making a self payment of the required rate as set by the Trustees subject to the provisions and limitations of Section 2 below. The self-payment amount will be subsidized by 50% for all first year apprentices and by $100 for all other eligible employees.

(2) A member may continue his eligibility by making a self-payment as set forth in Section 5.(1) above for a period up to (6) six months if he is actively seeking work through Local Union No. 33 - Youngstown District, as defined below, and has had his eligibility terminated for any of the following reasons:

a. is laid off or is unemployed;

b. is on strike;

c. is disabled, so as to be prevented from performing his normal duties.

To be actively seeking work, a member must maintain membership through Local Union No. 33 - Youngstown District and register at least every 30 days with the Local Union and is available for work.

If a member is on an authorized leave of absence granted in accordance with the terms of the Bargaining Agreement, or by reason of union activities or governmental service or actively related to the construction industry, he may continue his eligibility during the leave of absence period.

(3) Once you have exhausted your self payments or fail to make your self payments as required under the Plan, you may still be entitled to continue your eligibility under the provisions as set forth in the section entitled COBRA Continuation Of Coverage Option. The amount required for payment to maintain eligibility under COBRA shall be the COBRA rate established by the Trustees.

6. REINSTATEMENT OF ELIGIBILITY

If eligibility is terminated because hourly requirements have not been met and the required self-payments have not been made, a member shall become eligible again when credited with a minimum of 270 hours of employment in three consecutive months provided the reinstatement occurs within 12 months of termination.

Eligibility will be effective the month immediately following the completion of the reinstatement requirement. The reinstatement provisions are illustrated by the following table:

Eligibility Month in Which You Satisfied the 270 Hour Accumulation	Reinstated Quarter Beginning
January	February
February	March
March	April
April	May
May	June
June	July
July	August
August	September
September	October
October	November
November	December
December	January

If you should fail to be reinstated within 12 months of termination, you shall only again become eligible for benefits upon completion of the initial eligibility requirements.

7. CREDITING OF HOURS DURING DISABILITY

An eligible employee will be credited with three hours a day to a maximum of 20 hours per week for a period not to exceed 26 weeks for the purpose of maintaining eligibility as follows:

(a) While receiving weekly accident and sickness benefits from the Fund;

(b) While receiving weekly compensation from the Industrial Commission (Workers' Compensation); or

(c) While working light duty as a result of a work injury. The eligible employee's light duty employment must be with a contributing employer in a position which does not qualify for fringe benefit contributions.

To receive credit when you are receiving weekly compensation from the Industrial Commission or while working at a qualify light duty position as outlined above, you must contact the Fund office and provide appropriate documentation showing the amount of compensation received and the period for which the compensation has been paid.

8. COVERAGE DURING AND SUBSEQUENT TO SERVICE IN THE UNIFORMED SERVICES (MILITARY SERVICE)

Uniformed Service: "Uniformed Service" means the Armed Forces, the Army National Guard and the Air National Guad when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

Service in the Uniformed Services: "Service in the Uniformed Services" means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any duty, and a period for which a person is absent from employment for the purpose of performing funeral honors duty as authorized by Section 123503 of Title 10 or Section 115 of Title 32.

Any eligible employee who becomes absent from his position of employment by reason of service in the uniformed services shall be entitled to elect continuing coverage for himself and his dependents. This right to elect coverage exists even if the eligible employee will also be covered under a military health plan.

In order to be entitled to continuing coverage, the eligible employee must give advance written or verbal notice of uniformed service to his employer and the Fund Office. This notice will only be excused if the giving of such notice is precluded by military necessity, or if under the circumstances giving notice is deemed otherwise impossible or unreasonable.

Any eligible employee who elects continuing coverage may be required to pay for said coverage as follows:

(a) In the case of an eligible employee who performs service in the uniformed services for less than 31 days, such eligible employee may not be required to pay more than the normal employee contribution rate;

(b) In the case of an eligible employee who performs service in the uniformed services for more than 30 days, such eligible employee may be required to pay not more than 102 percent of the full premium under the Plan.

In the event the eligible employee has a reserve of bank hours, he may use the bank hours in order to cover monthly premiums until all bank hours are exhausted. Thereafter, the eligible employee will be responsible for paying premiums as outlined above. If the eligible employee does not elect continuing coverage, the individual's hour bank shall be frozen until such time as he returns from uniformed services and re-enters employment.

Additionally, if an employer so chooses, it may voluntarily pay the full premium for coverage under the Plan for service members and their families.

The maximum period of coverage available under this election shall be the lesser of:

(a) 24 months from the date on which the eligible employee's absence begins; or

(b) the day after the date on which the eligible employee fails to apply for or return for a position of employment, as set forth below.

Upon the completion of service in the uniformed services, the eligible employee shall notify the Fund Office and his employer of the intent to apply for or return to a position of employment as follows:

(a) In the case of an eligible employee whose period of service in the uniformed services was less than 31 days, by reporting to the employer:

(i) not later than the beginning of the first full regularly scheduled work period on the first full calendar day following the completion of the period of service and the expiration of eight hours after a period allowing for the safe transportation of the eligible employee from the place of that service to the eligible employee's residence; or

(ii) as soon as possible after the expiration of the eight-hour period referred to in clause (I), if reporting within the period referred to in such clause is impossible or unreasonable through no fault of the eligible employee

(b) In the case of an eligible employee who is absent from a position of employment for a period of any length for the purposes of an examination to determine the eligible employee's fitness to perform service in the uniformed services, by reporting in the manner and time referred to in subparagraph (a) above.

(c) In the case of an eligible employee whose period of service in the uniformed services was for more than 30 days but less than 181 days, by submitting an application for re-employment with the employer not later than 14 days after the completion of the period of service or if submitting such application within such period is impossible or unreasonable through no fault of the eligible employee, the next first full calendar day when submission of such application becomes possible.

(d) In the case of an eligible employee whose period of service in the uniformed services was for more than 180 days, by submitting an application for re-employment with the employer not later than 90 days after the completion of the period of service.

An eligible employee who is hospitalized for, or convalescing from, an illness or injury incurred in, or aggravated during, the performance of service in the uniformed services shall, at the end of the period that is necessary for the eligible employee to recover from such illness or injury, report to his employer (in the case of person described in subparagraph (a) or (b) above or submit an application for re-employment with such employer (in the case of a person described in subparagraph (c) or (d) above). Except as provided below, such period of recovery may not exceed two years.

Such two-year period shall be extended by the minimum time period to accommodate the circumstances beyond such eligible employee's control which make reporting within the period specified above impossible or unreasonable.

Upon an eligible employee's honorable discharge and return from the uniformed service, the eligible employee shall have the right to immediate reinstatement of coverage under the Plan upon re-employment without being subject to any exclusion or waiting period, provided the eligible employee fulfills the notice requirements outlined above. However, coverage will not be afforded for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. In addition to the required notice, the eligible employee shall also supply the Fund Office with copies of his discharge papers showing the date of his induction or enlistment in uniformed service and the date of his discharge. Failure on the part of the eligible employee to file such documentation with the Fund Office and/or provide the above notice may be deemed an indication that the eligible employee does not wish to restore his eligibility status under the Plan.

It is extremely important, if you wish to have a continuation of benefits under USERRA, that immediately upon learning of your armed service related absence for any period, you discuss your options with the Fund Office.

VI. RULES OF ELIGIBILITY – RETIREE COVERAGE

Your eligibility for benefit coverage will continue so long as your hour bank permits, including self-payments for the eligibility quarter with insufficient bank dollars for the corresponding benefit quarter provided you have retired and you are not engaged in disqualifying employment as defined below. If you become eligible for coverage under Medicare before exhausting the amount in your hour bank, any remaining balance may be used for the purchase of an individual Medicare supplemental benefits policy. An appropriate receipt must be presented to the Fund office. You will continue to receive reimbursement on this basis until the balance in your hour bank is used up, or the Trustees eliminate this program. To be eligible for reimbursement, you must be enrolled in Medicare Parts A & B.

After retirement, you and your dependent's eligibility for benefits available under the health and welfare Plan coverage will be terminated if you engage in disqualifying employment. Disqualifying employment for this purpose is defined as:

1. Employment in work of any type covered by the terms of the Collective Bargaining Agreement in effect between the Union and the Association, or in any type of work normally performed by Sheet Metal Workers; and

2. Self-employment in the same or related business as any Contributing Employer.

VII. RULES OF ELIGIBILITY – PRE-RETIREMENT FUNDING PROGRAM

1. To be eligible for this benefit a retiree participant must have been an active Plan participant on the date of his or her retirement and must maintain continuous coverage in the Plan until age 57 and at age 57 must elect coverage under this program within sixty (60) days. Prior to June 1, 2008 the age requirement was 58.

2. This benefit is available to retiree participants only between the ages of 57 up to age 65.

3. Each eligible participant, having single coverage after acquiring ten (10) years of credited service, shall receive a credit of $5.68 for every year of credited service up to a maximum of thirty (30) years as an offset to his or her required self-payment. Each eligible participant, having family coverage after acquiring ten (10) years of credited service, shall receive a credit of $11.36 for every year of credited service up to a maximum of thirty (30) years as an offset to his or her required self-payment. For example, after 12 years of credited service, a single participant's self-payment would be reduced monthly by $68.16 ($5.68 x 12).

The following chart is illustrative of the participant's cost based upon current premium rates and achieved offsets from the Fund if all service was earned after July 1, 2009:

Years of Credited Service	Self-Pay Monthly Premium Single Coverage	Self Pay Monthly Premium Family Coverage	Payment from Fund for Single Coverage	Payment from Fund for Family Coverage	Single Coverage You Pay	Family Coverage You Pay
0 - 10	$389.00	$776.00	$ 0.00	$ 0.00	$389.00	$776.00
10	$389.00	$776.00	$ 56.80	$113.60	$332.20	$662.40
15	$389.00	$776.00	$ 85.20	$170.40	$303.80	$605.60
20	$389.00	$776.00	$113.60	$227.20	$275.40	$548.80
25	$389.00	$776.00	$142.00	$284.00	$247.00	$492.00
30	$389.00	$776.00	$170.40	$340.80	$218.60	$435.20

4. The benefit extends to a surviving spouse but only to the date of the retiree's 65th birthday.

5. Retirees must deplete their bank hours before receiving this benefit. Payments deducted for the bank hours will be assessed at the self-payment rates established for this Plan.

6. Any Fund participant who has at least ten (10) years of credited coverage in the Fund shall be eligible for this retiree benefit provided he or she has worked as a Local 33, Youngstown District Sheet Metal workers and received credited coverage by having contributions paid or self-payments made on his or her behalf into the Fund for the consecutive five (5) year period prior to his or her date of retirement, and no longer performs Sheet Metal work and has not performed Sheet Metal work since his or her retirement.

7. Credited coverage means the payment of contributions or self-payments to the Fund for no less than 1600 hours of employment per year.

VIII. RULES OF ELIGIBILITY – DEPENDENT COVERAGE

Your eligible dependent(s) becomes covered on the date you become eligible provided you have registered them with the Fund within 31 days after the date you become eligible. If you elect dependent coverage more than 31 days after you become eligible, coverage is effective when approved by the Fund. The Fund may require evidence of insurability of each dependent before agreeing to cover them. However, a dependent child born while you are covered for dependent coverage will become covered immediately. You must enroll the newborn child within the first 31 days of life or the adoptive children within 31 days from date of placement for coverage to continue after the 31st day.

In the event of an employee's death while eligible under the Fund, eligibility for his dependents shall continue to the normal termination of eligibility date based upon the deceased member's hour bank balance, with a minimum of one quarter beyond the quarter in which the member died.

Dependent coverage is available to the following:

- your lawful spouse;

- any of your unmarried children under age 19; or
- any of your unmarried children under age 25, who are attending school full time.

"Children" includes stepchildren so long as they qualify as dependents for Federal income tax purposes.

No person eligible for coverage as an employee can be covered as a dependent; no person may be the dependent of more than one employee.

Qualified Medical Child Support Orders
A Qualified Medical Child Support Order (QMCSO) is a judgement, decree, or order made pursuant to a state relations law (including community property law) setting forth provisions regarding the support for a child of a Participant (alternative recipient) and which:

(a) Creates or recognizes the existence of an Alternative Recipient's right to, or assigns to an Alternative Recipient the right to receive benefits for which a Participant or beneficiary is eligible under this Plan; and

(b) Specifies (i) the name and last known mailing address (if any) of the participant and each Alternative Recipient covered by the Order, and (ii) a reasonable description of the type of coverage to be provided by the Plan or the manner in which the coverage is to be determined; and

(c) Does not require the Plan to:

(i) Provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of any law relating to medical child support as described in Section 1908 of the Social Security Act.

(ii) Upon receipt of any judgement, decree or order (including approval of a property settlement agreement) relating to the provision of payment by the Plan to an Alternative Recipient pursuant to a state domestic relations law, the Board shall promptly notify the affected Participant and any Alternative Recipient of the receipt of such judgement, decree or order and shall notify the affected Participant and any Alternative Recipient of the Board's procedures for determining whether or not the judgement, decree or order is a Qualified Medical Child Support Order.

(iii) The Trustees shall establish procedures to determine the status of a judgement, decree or order as a QMCSO, and to administer Plan benefits in accordance with Qualified Medical Child Support Orders. Such procedures shall be in writing, shall include a provision specifying the notification requirements enumerated in the preceding paragraph, and shall permit an Alternate Recipient to designate a representative for receipt of communications from the Trustees and shall include such other provisions as the Trustees shall determine, including provisions required under regulations promulgated by the Secretary of the Treasury. A copy of such procedures is available without charge, upon request, from the Office of the Administrative Manager.

Surviving Spouse of Retired Participant

a) Rules for Eligibility

If you are an Eligible Retired Participant upon the date of your death, your spouse will be eligible to continue coverage under the Surviving Spouse Program offered by this Plan until the earlier of:

(I) your spouse becomes eligible to participate in a group hospitalization program offered by his or her employer; or

(ii) your spouse becomes covered under another group program, including Medicare; or

(iii) your spouse remarries.

In the event that the benefits of the group hospitalization program offered by surviving spouse's employer are, in the judgment of the Trustees, significantly less than the benefits offered by this Plan, the Trustees, at their discretion, may permit the surviving spouse to continue to participate in this Plan, provided timely contributions established by the Trustees are remitted.

(b) Eligibility Date

If you are an Eligible Retiree (Under Age 65), your spouse will become eligible to elect coverage in the Surviving Spouse Program upon the date of your death.

Your spouse will be required to make application for coverage in the Surviving Spouse Program within sixty (60) days of the eligibility date listed above and remit timely monthly contributions at the rate established by the Trustees.

IX. EXPLANATION OF BENEFITS

The following describes the Covered Services available when provided and billed by Providers. These Covered Services must be Medically Necessary unless otherwise specified.

Your Plan has contracted with a Claims Payor (Medical Mutual of Ohio serving Ohio and MultiPlan serving other states) in order to provide improved services and benefits for you and your Dependents. Accordingly, there are situations in which you may be responsible for the costs of your Medical Benefits even though they are otherwise covered under this Section of which you must be aware. The Claims Payor has contracts with Providers and Physicians which afford the Plan and you discounts and improved benefits. However, the Claims Payor may not have a contract with your particular hospital or physician. You should be aware of whether your hospitals and physicians are in the network of providers under your Claims Payor. If your hospital or physician is not included in your Claims Payor's Network, the Provider or Physician is not bound by a payment arrangement with your Claims Payor and you may be responsible for all or a portion of the charges. All charges applied to deductibles and co-insurance amounts are always your responsibility. If you have any questions, please call the Fund Office. To verify whether a doctor or hospital participates, you may use the directory, contact Medical Mutual at 1-800-601-9208, visit the Website at www.supermednetwork.com, or ask the medical provider.

The Plan pays for these Covered Services as specified in the Schedule of Benefits. See Section I.

1. **YOUR DEDUCTIBLE**

In-network benefits will be subject to the deductible shown in the Schedule of Benefits, after which all eligible charges will be payable at 80% up to a maximum of $2,500.00 of eligible charges for an individual participant and $5,000 of eligible charges for a family, with 100% payment thereafter for the remainder of that calendar year. The benefits for out-of-network providers will be subject to a separate deductible as shown in the Schedule of Benefits after which all eligible charges will be payable at 70% up to a maximum of $2,500 for an individual and $5,000 for a family, with 100% payment thereafter for the remainder of that calendar year.

Deductible amounts are based on a Calendar Year from January 1 through December 31 and must be met each year.

Deductible Carry-over: Covered Expenses incurred during the last 3 months of the Calendar Year which are used toward satisfaction of the deductible can be carried over and used to satisfy the next calendar year's deductible.

2. **WELL CHILD CARE:**

Birth to 1 year - Coverage for a History and Physical examination, development assessment, anticipatory guidance and laboratory services and immunizations at birth, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months/1 year. Intervals are based on the current Recommendations for Preventative Pediatric Health Care of the American Academy of Pediatrics.

Immunizations will be covered based on physician recommendation as the AAP schedule for immunizations varies based on the latest medical findings or research.

3. **EMERGENCY SERVICES:**

A. **Emergency Admission Services**. Services that relate to an admission as an Inpatient in a Hospital directly from a Hospital emergency room for the sudden and acute onset of an injury, ailment, condition, disease, disorder or illness with acute symptoms that are so severe that you are considered to be unstable and unable to be transferred to another Hospital and which, in the absence of immediate and ongoing medical attention as an Inpatient, would reasonably result in:

- permanently placing the Covered Person's health in jeopardy;
- serious impairment to bodily functions;
- serious and permanent dysfunction of any body organ or part; or
- other serious medical consequences.

B. **Emergency Accident Care.** In order for the following services to be considered Covered Services, they must be the result of an accident which occurred while this coverage is in effect and be rendered within seventy-two (72) hours of the occurrence of the accident. We will provide coverage for:

- outpatient hospital services.
- medical, surgical and anesthesia services.
- diagnostic tests and services.

- ambulance services to and from the hospital.
- physical therapy.
- private duty nursing.
- the application of splints and casts to broken bones.
- crutches, splints, bandages, medications and dressings.

For purposes of this Benefit, the Plan defines an Accident as an unforeseen injury to the body caused by unexpected, sometimes violent means.

C. Emergency Outpatient Hospital Services.
- Medical, surgical and anesthesia services.
- Diagnostic tests and services.
- Ambulance services to and from a Hospital.
- Physical Therapy.

D. Emergency Private Duty Nursing.
- the application of splints and casts to broken bones.
- Crutches, splints, bandages, medications and dressings.

E. Emergency Medical Care. The interpretation of diagnostic tests and the treatment of a Medical Emergency are covered which include heart attacks, strokes, loss of consciousness or respiration, convulsions and other acute conditions which the Plan determines to be Medical Emergencies. A condition will be considered a Medical Emergency only if the treatment is due to a sudden onset of an acute condition with symptoms which appear life-threatening or disabling and require immediate medical attention and/or surgical care to prevent serious physical impairment or loss of life.

If Emergency Facilities are used and it is determined by the Plan that the situation was neither an Accident or Medical Emergency, Covered Services will be paid at the level of coverage stated in the Schedule of Benefits under Non-Emergency Care.

4. MEDICAL-SURGICAL BENEFITS

SURGICAL SERVICES:
Surgical, Anesthesiologist and Assistant Surgeon: Benefits are described in Schedule of Benefits.

Charges by the doctor administering anesthesia and the doctor assisting the surgeon will be a covered expense under this benefit on the same basis as charges by the doctor performing the surgery; provided the anesthesia is not administered by the surgeon or by the assistant surgeon.

Multiple Surgical Procedures: If two or more surgical procedures are performed through the same body opening during the course of the same operative period, the total benefit shall be computed as follows: 100% for the procedure with the greatest benefit, plus 50% for each additional procedure. In no event shall any additional allowance be made for any incidental procedures performed during the operative session.

Maternity: If while covered for this benefit, a covered person incurs covered expense for pregnancy or its termination, the Fund will pay the benefit shown in the schedule of benefits. When the pregnancy is terminated, it includes non-elective Caesarean section, ectopic pregnancy, miscarriage, and therapeutic abortion (whether or not the

abortion is medically necessary). A complication of pregnancy is treated under the plan as an illness separate from pregnancy. Benefits available for pregnancy or its termination have no effect on a claim for expense incurred for a complication of pregnancy.

Routine Nursery Care: Hospital charges for room and board, supplies and services including circumcision, if applicable, for a newborn child while the mother is hospital-confined due to delivery. Routine Nursery Care extends for a maximum of five days.

In-Hospital Medical Care: Your plan covers physician's visits to a registered bed-patient in a hospital for the 365 days of a hospital confinement. After the initial 365 days, payment will be made for additional 365-day periods for the same or related conditions if a lapse of 90 days has occurred between the patient's discharge and next admission to the hospital.

Preventative Care Benefit: The Plan will pay charges subject to the maximum in the Schedule of Benefits for Routine Preventative Care Benefits, as follows:

- One routine Papanicolaou test (pap test) per Calendar Year and office visit incidental to such test;
- Routine mammograms and any office visit incidental to such test;
- Charges for routine physical examinations, x-rays, hearing tests, flu shots, laboratory tests, electrocardiograms, and other preventative care services not necessary for the treatment of any Injury or Sickness.
- Immunizations - Pediatric Immunizations from age 1 to age 15 based on physician recommendation and the American Academy of Pediatrics (AAP) recommended immunization schedule
- Adult Immunizations (Tetanus, toxoid, rabies, hepatitis B, pneumonia vaccine, etc.);
- Routine Prostate/PSA screenings;
- Routine Endoscopies / Colonoscopies;

5. HOSPITAL SERVICES

When you are admitted as a bed patient to any state approved hospital, you will be entitled to all the following services of the hospital as medically needed and to the extent available for:

Inpatient Hospital services

Bed, board, and general nursing services

- a room with two or more beds;
- a private room, if the hospital has no semiprivate rooms available. The private room allowance is the hospital's average semiprivate room rate.
- a bed in a special care unit approved by us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary Services

- operating, delivery and treatment rooms and equipment,
- prescribed drugs;
- anesthesia, anesthesia supplies and services given by an employee of the hospital or Other Provider;
- medical and surgical dressings, supplies, casts and splints;
- diagnostic services;
- therapy services:

Outpatient Hospital Services for:

- Emergency accident and medical care: services and supplies to treat injuries caused by an accident; or to treat a sudden and acute medical condition that is life threatening and requires prompt medical care (e.g. heart attacks, kidney stones, strokes)
- Surgery: Surgical services and supplies.
- Preadmission testing: If a doctor orders tests on a covered person in the outpatient department of a hospital preparatory to surgery to be performed in the same hospital, the Fund will pay the benefit shown in the schedule of benefits if:
  a. the tests are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is planned,
  b. the hospital inpatient room is reserved before the tests are performed;
  c. the surgery is performed within 7 days after the tests: and
  d. the tests are accepted in place of the same tests that would otherwise be performed upon confinement.

The Fund will pay for such tests even is surgery is postponed or cancelled;
  a. as a result of the tests;

6. **DIAGNOSTIC SERVICES**:

The following services when performed for the diagnosis of a condition, disease or injury and the physician's interpretation of these examinations are covered under your plan:

- X-ray Examinations
- Laboratory and Pathology Services
- Diagnostic Medical Examinations such as EKG's and EEG's
- Cardiographic, encephalographic and radioisotope tests

Diagnostic services may be provided either in or out of a hospital.

7. **THERAPY SERVICES**:
Hospital and Physician services or supplies used to promote recovery from an illness or injury include:

Radiation Therapy - The treatment of disease by X-ray, radium, or radioactive isotopes.

Chemotherapy - Treatment of malignant disease by chemical or biological antineoplastic agents.

Dialysis Treatments - The treatment of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.

Spinal Manipulation - The treatment for spinal manipulation is limited to $1,000 per calendar year. Treatment must be medically necessary and not maintenance to be eligible. Further treatments are available subject to a review of documentation stating medical necessity. Benefits will be limited to $1,000 a year for covered expenses rendered in connection with correction of nerve interference and its effects by manual or mechanical means where the interference results from or is related to distortion, misalignment or subluxation of or in the vertebral column.

Physical Therapy - Services of a licensed physical therapist, when certified by an attending physician. The individual may be required to have an independent medical examination by a provider selected by the Trustees.

Speech Therapy - Treatment by a licensed speech therapist to retrain and restore speech function after illness, the Fund will pay the covered expense incurred, but not more than the benefit shown in the schedule of benefits. Benefits are not payable for speech therapy to correct learning problems or developmental speech impediments with no medical cause, but benefits are payable for covered expense incurred in the initial diagnosis of the problem. For the purpose of this provision, "illness" includes congenital defects.

8. **HOSPICE CARE SERVICES**:
If while covered for this benefit, a covered person begins a hospice care plan, the Fund will pay the covered expense incurred but not more than the benefit shown in the schedule of benefits. However, the person's attending doctor and a hospice program doctor must certify in writing, on or before the date the initial hospice care begins, that the person: (1) is terminally ill; (2) has a medical prognosis of six months or less to live; (3) is a candidate for palliative care rather than treatment to cure the illness; and (4) has chosen in writing hospice care according to a hospice care plan. Recertification of 1, 2, 3 and 4 will be required before hospice care benefits can be paid beyond the maximum benefit period shown in the schedule of benefits.

The benefits provided under this provision are in place of all other benefits determined by the Fund to be related to the treatment of that person's terminal illness. Other medical care benefits provided under this Section can be resumed, if (1) the person revokes in writing his election for hospice care or (2) he receives the maximum hospice care benefit as shown in the schedule of benefits.

Covered. The following services and supplies for hospice care will be covered expenses under this benefit, and other "covered expense" as defined in this Section will be covered only if provided as part of a hospice care plan and not for the cure of the terminal illness:

1. charges by a hospice facility for:
    a. in-patient care, but not more than the average semiprivate room rate charged by hospitals in that geographic area; or
    b. respite in-patient care, but only to the extent such care is occasional, non-routine and intermittent for periods of 5 days or less;
2. medical social services provided by a social worker under the direction of a doctor;
3. home health care to the extent that it is included as part of the hospice care plan.

Not Covered. Benefits will not be paid for the following Hospice Care services:

1. services provided by volunteers or others who do not regularly charge for their services;
2. counseling of any type which is not:
    a. provided by or through the hospice care plan; or
    b. for the sole purpose of adjusting to the terminally ill person's death;
3. services provided by homemakers, caretakers and the like;
4. funeral services and arrangements;
5. legal or financial counseling or services;
6. treatment intended to cure the terminal illness;
7. hospice care not recommended or started by the attending doctor or a hospice program doctor;
8. charges which are not for the palliation and management or a terminal illness; or
9. charges which are not payable because they are excluded under the Exclusions and Limitations provision of this Section.

9. **MENTAL OR NERVOUS ILLNESS**:
Treatment in or at a hospital or community mental health facility for a mental or nervous illness, the Fund will pay the covered expense incurred, but not more than the benefit shown in the schedule of benefits. "Community mental health facility" means a facility approved by a regional health planning agency or a facility providing services under a community health board established under the Ohio Laws. In order to determine the maximum benefit, two days of partial hospitalization will be considered one day of confinement. "Partial hospitalization" means continuous treatment consisting of not less than four hours and not more than twelve hours in any twenty-four hour period. No benefit will be paid under this provision for more than one outpatient treatment on the same day. This benefit applies to all expense incurred for the treatment of a mental or nervous illness.

10. **ALCOHOL OR DRUG ABUSE TREATMENT**:
If while covered for this benefit, a covered person is confined in a hospital or a treatment center for effective treatment of alcoholism, alcohol abuse or drug abuse, the Fund will pay the charge made by the hospital, the treatment center or the doctor, but not more

than the benefit shown in the schedule of benefits. If while covered for this benefit, a covered person is treated in a doctor's office or in the outpatient department of a hospital or a treatment center, the Fund will pay the charge made for the treatment, but not more than the benefit shown in the schedule of benefits.

"Treatment center" means a licensed institution or a unit of a licensed institution which meets these requirements:

a. it is contractually affiliated with a hospital with an established system of patient referrals;

b. it is licensed, certified or approved as an alcoholism or drug treatment center by the state in which it is located or accredited as such a facility by the Joint Commission on Accreditation of Hospitals; and

c. it provides all necessary medical detoxification services on its premises, 24 hours a day.

"Effective treatment" means a written program of therapy prescribed by a doctor designed (1) for withdrawal from the physiological effects of alcohol or drugs; and (2) as a complete program to help the person maintain sobriety or refrain from the use of drugs.

11. **AMBULANCE SERVICE**:
Transportation provided by professional ambulance service to and returning from the nearest hospital for inpatient care or outpatient care, and from a transferring hospital to the nearest hospital or sanitarium equipped to provide the necessary medical care required by a covered person.

12. **HOME HEALTH CARE SERVICES**:
If a doctor sets up or approves a home health care plan for a covered person, the Fund will pay the benefit shown in the schedule of benefits for each home visit in connection with such home health care plan.

One home care visit will consist of:

a. a visit from a member of the home health care team; or

b. 4 hours of service by a home health aide.

Home health care benefits will be paid only if:

a. the attending doctor certifies that in the absence of the plan, the patient would be confined in a hospital or an extended care facility; and

b. the plan is for care of the illness for which confined at home.

Not Covered. Benefits will not be paid for:

a. custodial care;

b. transportation; or

c. home services by a person who resides in the covered person's home

13. **BLOOD SERVICES**:
Whole blood, blood components, and blood processing administration. Your plan does not pay for the first two pints of whole blood or blood components or for pints which are replaced.

14. **MEDICAL SUPPLIES, EQUIPMENT AND APPLIANCES**:
Benefits will be paid for:

Durable Medical Equipment - The rental (or, at our option, the purchase) of durable medical equipment prescribed by a physician. Rental costs must not be more than the purchase price. This equipment must serve only a medical purpose and be able to withstand repeated use.

Prosthetic Appliances - Purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:

- replace all or part of a missing body organ and its adjoining tissues; or
- replace all or part of the function of permanently useless or malfunctioning body organ.

Orthotic Devices - A rigid or semi-rigid supportive device which limits or stops motion of a weak or diseased body part.

Medical and Surgical Supplies - Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered services do not include items usually stocked in the home for general use like adhesive bandages, thermometers, and petroleum jelly.

15. **ORGAN TRANSPLANTS**:
This plan provides coverage for human organ transplants for heart, heart-lung, pancreas, liver and bone marrow. Kidney transplants will be a covered expense payable as any other illness. Under this plan, benefits for covered services rendered by a physician and other professionals are paid at the usual, customary, and reasonable charge (UCR), or the actual amount charged, whichever is less, subject to the specifications listed in the Schedule of Benefits. A pre-determination from the physician must be obtained in writing for benefits to be provided. To obtain pre-determination, contact the Fund Office as soon as you know that you are a candidate for any one of these human organ transplants. A pre-determination is only granted if the human organ is medically necessary, the procedure is not experimental and if the transplant surgery is to be performed in an approved hospital.

This plan pays for medically necessary covered services related to transplant surgery if the expense is incurred during the five (5) days prior to the surgery and the 365 days thereafter. Benefits provided by this plan are only for covered services in relation to the human organ transplants specified. Benefit payments will not exceed the total lifetime maximum coverage (while covered by this plan) for all eligible benefits listed in the schedule of benefits.

Covered Services are:

- Hospital room, board, and general nursing in semi-private rooms and/or special care units that have been approved by pre-certification procedures.
- Hospital ancillaries while you are an inpatient.
- Physicians' services for surgery, technical surgical assistance, administration of anesthetics, and in-hospital medical care.
- Diagnostic x-rays and other radiological services, laboratory and pathology services; and EKG's, EEG's and radioisotope tests.
- Drugs which require a prescription by federal law and are not considered to be investigative or experimental.

With prior approval by the Fund Office, benefits will be paid for other services (such as home health care and certain therapy services) when such services are medically necessary, directly related to a covered transplant, and ordered by your physician.

Services and supplies rendered in connection with organ transplants which are considered to be investigative or experimental are not covered. Investigative and experimental services and supplies are those which are not generally accepted by the medical community as safe, effective treatment. This plan does not provide benefits for any expenses for an artificial organ.

16. **DENTAL SERVICES FOR ACCIDENTAL INJURY**:
Benefits will be paid for dental services rendered by a Physician or Dentist for an accidental injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident occurring on or after the Effective Date. Injury as a result of chewing or biting is not considered an accidental injury.

17. **EXTENDED CARE FACILITY**:
If a covered person who has been confined in a hospital for 3 or more days during the acute stage of an illness is moved to an extended Care facility within 14 days of discharge from the hospital, the Fund will pay the benefit shown in the schedule of benefits, as well as other services provided by the facility for the period shown in the schedule of benefits. Charges for prescription drugs will not be paid under this benefit. Benefits must have been payable while confined in the hospital. The attending doctor must certify that if not confined in the extended care facility, the patient would have to be confined in a hospital. Two or more confinements due to the same or related cause or condition will be considered to be in the same period of disability.

18. **EMPLOYEE LIFE INSURANCE**
The Fund will pay your beneficiary the life benefit amount in force on you upon receipt of due proof of your death while eligible under this Plan.

The amount of life insurance in force on you is shown in the schedule of benefits.

All benefits for loss of life are payable to the beneficiary designated by you. If there is no beneficiary living to whom all or part of the death benefit is payable, the Fund may, at its option, pay said amount to any one of the following then living:

- to your spouse;
- to your parent or parents:
- to your child or children; or
- to the executors or administrators of your estate.

The Fund may rely on the statement of any one of the above as to the persons then living in the specified categories. Payment in accordance with this provision will release the Fund from all liability for the amount so paid.

Beneficiary. You may designate a beneficiary or beneficiaries to receive a death benefit. You may, from time to time, change the designation of beneficiary. Any designation or change will take effect when received by the Fund at its Home Office but will relate back to the date of signing. The Fund, however, will be released from any liability for payment made before it receives the designation or change of beneficiary.

Benefits for Other than Loss of Life. All benefits other than for loss of life are payable to you after receipt of due proof of loss; except, if applicable, such benefits may be payable to the Qualified Beneficiary.

Payment of weekly income benefit (if any) will be made weekly during the period for which proof of disability has been furnished. Any balance which remains unpaid at the end of the period for which the Fund is liable will be paid at that time.

All other benefits are payable immediately upon receipt of due proof of loss.

19. ACCIDENTAL DEATH AND DISMEMBERMENT

The Fund will pay the benefit specified below when it receives due proof that:

1. you sustained an accidental bodily injury while eligible under this Plan;
2. your suffered a loss shown in the table below solely as a result of the injury; and
3. the loss occurred within 90 days of the accident.

Table of Losses	
Loss	Accidental Death and Dismemberment Benefit
Life	Benefit amount
Both hands, both fee or both eyes	Benefit amount
One hand and one foot	Benefit amount
One hand and one eye	Benefit amount
One foot and one eye	Benefit amount
One hand or one foot or one eye	Half of Benefit amount

The accidental death and dismemberment benefit amount is the maximum payable for all losses as a result of one accident.

For this purpose, loss means:

a. as to hands, severance through or above the wrist;

b. as to feet, severance through or above the ankle; and

c. as to eyes, entire and irrecoverable loss of sight.

The accidental death and dismemberment benefit amount is shown in the schedule of benefits.

Exclusions. No benefit will be paid for a loss which directly or indirectly results from:

a. suicide or intentionally self-inflicted injury;

b. combat, war - declared or not, or act of war;

c. physical or mental sickness or disease;

d. the taking of a drug, chemical or poison of any kind;

e. travel in an aircraft if:

   i. suicide or intentionally self-inflicted injury;

   ii. the aircraft is being used for training purposes; or

   iii. the aircraft is being used by the army, navy, air force, coast guard or other military unit; or

f. commission of a felony.

20. **PRESCRIPTION DRUGS**:
The Prescription Drug benefit is limited to an annual maximum of $25,000 per person and is paid as follows:

	Retail Program	**Mail Service Program**
When to Use it	For immediate drug needs or short-term medications	For maintenance or long-term medications
You Pay	• 10% with minimum of $10 for each generic prescription • 25% with a minimum of $25 for each brand name* prescription	• 10% with minimum of $10 for each generic prescription • 25% with a minimum of $25 for each brand name* prescription
Days Supply Limit	30-day supply or 100 units, whichever is greater	90-day supply
Fill Limit	3 fills allowed on maintenance medications only	None

Exclusions (but not limited to)	Over-the counter drugs Anti-wrinkle agents Nutritional Supplements Device Contraceptives Transdermal Contraceptives Injectable and Inter-Urethral Erectile Dysfunction** Glucose monitors	Cosmetic Products Hair Growth stimulants Contraceptive Ring Emergency Kit Contraceptives Fertility medications Diet medications Smoking cessation Lancet Devices
CareMark Customer Service	1-888-202-1654 or www.caremark.com	

* When a generic is available, but the pharmacy dispenses the brand name medicine for any reason other than physician indicates "dispense as written," you will pay the difference between the brand name drug and the generic plus the brand co–payment

** Except for four (4) pills per 30 days at retail or twelve (12) pills for 90 days via mail service for Viagra, Levitra or Cialis

21. WEEKLY SICKNESS BENEFIT

Covered Employees Only
Payments will be made at the Weekly Sickness Benefit rate stated in the Schedule of Benefits when Covered Employee is wholly and continuously disabled by an accidental bodily injury occurring off the job, or sickness not connected with employment that prevents him from working at his occupation and which requires the regular care and attendance of a legally qualified physician or surgeon. Benefits for Covered Employees begin with the 1st day of disability due to accidental bodily injury, or the 8th day of disability due to a sickness, and will continue up to the maximum number of weeks stated in the Schedule of Benefits for any one period of disability.

Successive periods of disability due to the same or related causes not separated by return to active employment for a period of two (2) full weeks shall be considered one period of disability.

To receive a Weekly Sickness Benefit, you must be disabled and not receiving wages from an Employer as a result of a non-work related injury or illness and you must be under a physician's care. You must be available for work and eligible when you became injured, ill or unable to work due to pregnancy. Only you, the Active Participant, are covered under Weekly Sickness Benefits. There are no Weekly Sickness Benefits for your legal spouse or dependents.

22. VISION CARE BENEFITS

The Vision Benefit covers eye examinations, lenses, frames, and contact lenses as stated in the Schedule of Benefits.

Limitations and Exclusions under the Vision Care Plan

Your Vision Care Plan does not provide benefits for professional services or materials in connection with:

1. Glasses or contact lenses secured when not medically necessary due to no change in prescription.
2. Orthoptics or vision training, subnormal vision aids, aniseikonia lenses, or plano (non-prescription) lenses.
3. Medical or surgical treatment of the eyes.
4. Services or materials provided as a result of any Worker's Compensation Law, or similar legislation, or obtained through or required by required government agency or program whether Federal, State or any subdivision thereof.
5. Any eye examination required by an employer as a condition of employment; or any service or material provided by any other vision care plan, or group benefit plan, containing benefits for vision care.
6. Charges for services or supplies which are covered in whole or in part under any other portion of the benefit plan of the Sheet Metal Workers Local No. 33 Youngstown District Health and Welfare Fund.
7. Plano (nonprescription) or prescription sunglasses. Tinted glasses with a tint above Number 2 will be considered sunglasses for this purpose.
8. Anti-reflective coatings.
9. Visual analysis which does not include refraction.
10. Services or supplies not listed as covered expenses in the Schedule of Vision Care Benefits. (Vision care expenses connected with disease or injury are covered under the medical benefits of the Fund).
11. A frame that requires oversize lenses.
12. Two pairs of glasses in lieu of bifocals.
13. Repair or replacement of lost, stolen or broken frames and/or lenses.
14. Special athletic glasses.

23. DENTAL CARE BENEFITS

The Trustees have contracted with Delta Dental to use their Point of Service program and network for payment of claims. Benefits are payable at 80% up to a maximum of $800 per family/per year. These benefits are not subject to the medical deductible or co-insurance responsibilities. In the event you seek treatment from a dentist that does not participate in any of Delta Dental's programs, you may be responsible for more than 20%.

See Appendix 1 for additional information regarding covered services, exclusions, limitations, and claims appeal procedures or contact the Customer and Claim Services department at (800) 524-0149 or visit the web site at www.deltadentaloh.com.

X. WHAT IS NOT COVERED

1. No covered expense will be used to compute benefits under more than one benefit provision. If a covered expense exceeds the amount on which a benefit is computed under one provision, the excess may be applied to another benefit provision. Covered expense will be applied to the benefit provision that provides the best benefit.
2. Benefits for the treatment of a mental or nervous illness will be covered expense only to the extent provided in a benefit provision which specifically applies to the treatment of mental or nervous illness.
3. This coverage does not cover, and covered expenses will not include, charges incurred:
   a. For examinations or tests not made as part of the treatment of illness.
   b. Unless the covered person would be legally required to pay the charge, even if there was no coverage.
   c. For private duty nursing care except as defined as a covered expense.
   d. For service in a facility provided by an employer or by a union employee benefit association or similar group of which the covered person is a member.
   e. For any care of treatment furnished by the employer or any of its employees.
   f. For reversal of sterilization.
   g. For sexual reassignment surgery and related treatment.
   h. Illness or injury arising out of or in the course of employment, or for a sickness covered by Worker's Compensation.
   i. Care received without cost under the laws of the United States or any political subdivision thereof.
   j. Disease or injury resulting from war, whether declared or undeclared, or from an act of war.
   k. Charges that exceed the Reasonable and Customary allowance.
   l. Services rendered for cosmetic purposes, unless made necessary by accidental injury occurring while the subscribers coverage is in effect. This includes, but is not limited to stomach stapling, breast augmentation and face lifting.
   m. Routine physical examinations and preventive care not incidental or necessary to the treatment of an illness or injury, except as specified elsewhere in this Plan.
   n. The treatment of illness or injury, or services or supplies not specifically listed as covered medical expenses.
   o. For services provided by a "Close Relative." Close relative means the spouse, parent, brother, sister or child of the covered person, or the spouse of the covered person's parent, brother, sister or child.
   p. Services for which there is no charge received from a dental or medical department maintained by or on behalf of an employer, mutual benefit

association, labor union, trust, or similar person or group of which the covered person is a member.

q. For a provider not charging for services.

r. For which payment was made or would have been made under Medicare Parts A or B if benefits were claimed. This applies when you are eligible for Medicare even if you did not apply for or claim Medicare benefits. However, if under law, you may elect this coverage, instead of Medicare, to pay first and if you so elect, then this exclusion will not apply.

s. To the extent those expenses are in any way reimbursable through any public program, other than Medicare.

t. For confinement in, or treatment received from, a hospital owned or operated by the United States government.

u. For charges which would not have been made had medical coverage not existed.

v. For a condition resulting from service in the armed forces of any country or service in a civilian unit serving with such forces.

w. For charges for appliances or restorations to increase the vertical dimension of the mouth or to restore the occlusion (bite).

x. For any treatment received before coverage became effective, or during an inpatient admission that commenced prior to the effective date.

y. To the extent that payment under this plan is prohibited by any law to which you or your family member is subject at the time expenses are incurred.

z. For unnecessary care or treatment, as determined by a review board.

aa. For or in connection with custodial care, education and training.

ab. To the extent those expenses are in any way reimbursable through "No Fault" automobile insurance.

ac. Any expenses incurred for any service or treatment which is not provided or recommended by a physician.

ad. Experimental services, procedures, or substances which have not been recognized as accepted standards of medical practice; (Federal Drug Administration, American Medical Association).

ae. Treatment of obesity or for weight reduction, including any care which is primarily dieting or exercise for weight loss.

af. Services and/or supplies furnished during periods when the patient is temporarily absent from the hospital.

ag. Services and/or supplies related to sex transformations or complications thereof.

ah. Services and/or supplies for personal comfort items such as television, telephone, admission kits, lotion, powder, etc.

ai. Exercise equipment.

aj. Nutritional supplements.

ak. Services rendered or billed for, by a school or halfway house or by a member of its staff.

al. Any confinement in an institution primarily to change or control one's environment (milieu therapy) .

am. Invitro fertilization, artificial insemination, surgical reversal of elective sterilization, or any charges relating to infertility.

an. Services and/or supplies for treatment of an accident or illness resulting from commission of a felony or active participation in a riot.

ao. For any care or treatment furnished by an employer or any of its employees.

ap. For treatment of sexual problems not caused by organic disease.

aq. For dental procedures, except as specified elsewhere in the Plan or for treatment of accidental injury and surgical removal of boney impacted teeth.

ar. Radial keratotomy or keratoplasty.

as. Chelation therapy.

at. Telephone consultations, missed appointments, or completion of claim forms.

au. Foot care only to improve comfort or appearance such as care for flat feet, subluxation, corns, bunions, calluses, toenails (except capsular, bone surgery) or arch supports or corrective shoes.

av. For hearing aids or examinations for prescribing or fitting them.

aw. For conditions related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems or mental retardation.

ax. Incurred after your cancellation date except as specified in the Benefits after Termination Section.

ay. Charges billed by a massotherapist.

az. For charges and/or services relating to temporomandibular joint dysfunction.

ba. Expenses incurred after termination of this plan.

bb. For hospital admission which begin on a Friday or Saturday; but only the hospital expense for those days, and only if surgery does not occur on either of those days and the admission is not an emergency. "Emergency' means that the admission cannot be scheduled at the convenience of the patient or his doctor without endangering the patient's health or causing him to become permanently disabled.

4. No benefits will be paid for illness, injury, or condition existing before the covered person was eligible. This exclusion will not apply to expense incurred after the first to occur of the following:

a. a 3 month period ending during which the eligible person receives no medical treatment or services and takes no drugs or medicines for the illness; or

b. the covered person has been eligible for this coverage continuously for 6 months.

The Fund will, in any event, pay benefits not exceeding $2,000 for covered expense which would otherwise not be covered because of this exclusion.

XI. PRE-EXISTING CONDITIONS PROVISION

If an Eligible Member has been treated for an injury or illness within six (6) months prior to becoming eligible for benefits under the Plan, then all expenses incurred as a result of such injury or illness will not be considered as eligible expenses until twelve (12) months after the effective date of coverage.

The pre-existing condition coverage exists for 12 months (18 months for late enrollees) after becoming eligible for benefits under the Plan. This period is reduced, however, by counting certain prior coverage toward the exclusion period. Employees with 12 months of coverage with one employer may, therefore, move to a new employer with new coverage without becoming subject to the pre-existing condition exclusion of the new employer.

An employee is credited for prior coverage under a wide variety of health plans, including group health plans, individual policies, HMOs, Medicare, and various governmental programs. Coverage is not counted toward the exclusion period of the new plan, however, if there has been an intervening break in coverage of 63 days or more. Only coverage after the break may be credited.

A special 30-day period also applies for enrollment of new dependents acquired by marriage, birth, adoption, or placement for adoption. No pre-existing condition exclusion may apply to pregnancy, pregnancy-related conditions, newborns or adoptees enrolled during this period, but the 12-month exclusion could apply to a new spouse or child placed for adoption but not yet adopted.

XII. CERTIFICATE OF CREDITABLE COVERAGE

This Plan and an individual's prior plan must supply you with a certification of coverage at the time coverage ceases, or, upon your request. You may also request a certificate, free of charge, from the Administrative Manager until twenty-four (24) months after the time your coverage ended. For example, you may request a certificate even before the coverage ends. The certification must specify the period of creditable coverage.

If you do not receive a certificate by the time you should have received it or by the time you need it your first step should be to contact the Administrative Manager of the prior plan responsible for providing the certificate and request one. If any part of your credible coverage was through an insurance company, you can also contact the insurance company for a certificate that reflects that part of your credible coverage as long as you make the request within twenty-four (24) months of your coverage ceasing under the insurance policy.

In any event, if you do not receive a certificate, you may demonstrate to the Plan that you have credible coverage (as well as the time you were in any waiting period) by producing documentation or other evidence of credible coverage (such as pay stubs that reflect the deduction for health insurance, explanation of benefit forms (EOBs) or verification by a doctor or your former health care benefits provider that you had prior health insurance coverage.

Once you obtain a certificate, keep it in case you may later need it. You will need the certificate if you leave your health plan and enroll in a subsequent plan that applies a preexisting condition exclusion, or if you purchase an individual insurance policy from an insurance company.

XIII. HOSPITAL AUDIT BONUS PROGRAM

If a covered person submits an adjusted hospital bill after finding charges for services or supplies that were not actually provided, the Fund will pay him or her 50% of any benefit the hospital refunds the Fund, up to a maximum benefit of $500. The bill must be for charges that would have been covered expenses under the policy.

This program does not apply to:

1. unsupported hospital charges of less than $10; or
2. errors or discrepancies found by the Fund during a 90-day review period from the Fund's processing of the claim

XIV. COORDINATION OF BENEFITS (COB)
WHEN YOU OR YOUR DEPENDENTS HAVE OTHER COVERAGE

Benefits Subject to the COB Provision. This provision applies only to those coverages shown in the schedule of benefits which provide benefits on account of certain hospital, surgical, medical or dental expenses covered under the policy.

Definitions. As used in the COB provision:

1. "Plan" means any of the following under which benefits are payable or services are provided for medical or dental treatment:
   a. group, blanket or franchise insurance;
   b. a pre-payment service type arrangement, such as a group Blue Cross, group Blue Shield, individual and group practice plans, and health maintenance organizations;
   c. an employer(s), union(s) or joint employers(s)/union trust or other organization or employee benefit association;
   d. a plan or program solely or largely tax supported or provided by or through government action, other than Medicare or Medicaid; or
   e. to the extent permitted by law, an automobile liability policy paying benefits without regard to fault (no-fault).

Each plan or part of a plan which has a right to coordinate benefits will be considered a separate plan.

2. "This plan" means any hospital, medical, major medical or dental insurance benefits, is a part of the policy.

3. "Allowable expense" means a necessary, reasonable and customary item of expense, all or a part of which is covered under one of the plans covering the person for whom claim is made.

4. "Claim period" means a calendar year or that part of the year in which the person has been insured under this plan. The definitions in the other section apply also to the COB provision.

When the COB Provision Applies. If, for any claim period, the sum of:

a. the benefits payable under this plan in the absence of the provision; and

b. the benefits payable under all other plans in the absence of similar provision would exceed the allowable expenses incurred for a covered person, this provision applies.

Except as provided below, benefits under this plan will be reduced to the extent required so that the sum of:

a. the reduced benefits under this plan; and

b. all benefits payable for allowable expenses under all plans does not exceed the total of allowable expenses. Benefits payable under a plan include benefits that would be payable if proper claim were made. If a plan's benefits are in the form of services, the reasonable value of the services will be both an allowable expense and a benefit paid.

Benefits of another plan will be ignored in determining the reduction if:

a. the order of benefits rules of this plan required this plan to determine benefits before the other plan; and

b. the other plan has a coordination provision that would, under its rules, determine its benefits after this plan.

When benefits are reduced, each benefit payable will be reduced pro rate. The reduced amount will be charged to any benefit limits in this plan.

Order of Benefit Rules. The rules which follow describe in descending order which plan is primary when there are two or more plans. As used here, "primary" means the benefits of a described plan will be determined before the benefits of another plan:

1. The plan which covers the person as an employee will be primary.

2. The plan of the parent whose birthday occurs first in a year will be primary for a dependent child who is covered under both parents' plans; if a Plan does not have this rule, the rules of that plan will determine which plan is primary.

3. Rule 2 will not apply if the parents are divorced or separated. In that event, the plans will be primary in this order:

   a. first, the plan of the parent with custody;

b. next, the plan of the spouse of the parent with custody; and

c. last, the plan of the parent without custody.

However, if there is a court decree establishing one parent as financially responsible for the child's medical or dental expenses, the plan of the parent with that responsibility will be primary.

4. If the person is a laid-off or retired employee, the plans will be primary in this order:

   a. first, the plan which covers the person as an active employee (or as that employee's dependent);

   b. next, the plan covers the person as a laid-off or retired employee (or that employee's dependent); and

   c. last, all other plans.

This rule will not apply if a plan covering the person has no provision for laid-off or retired employees and, as a result, each plan considers the other plan or plans as primary.

5. When none of the preceding rules apply, the plan covering the person for the longer period of time will be primary.

XV. CLAIMS AND APPEALS PROCEDURES

1. **How to File Claims for Medical Benefits**

When you receive health care services:

- Show your identification card to the provider of the service
- Ask the provider to file a claim for you

If your provider of the medical service is a Participating Provider in the Medical Mutual Network, he/she will submit all necessary claim information to Medical Mutual on your behalf. Medical Mutual will forward the claims to the Fund's Administrative Office to be reviewed and paid. The Fund's Administrative Office will provide reimbursement from the Fund to the provider directly.

If you do not use a provider who is part of the Medical Mutual Network, you may have to submit a claim for benefits directly to the Fund. If you must submit a claim for health care services received, you should:

- Obtain an itemized bill from the hospital, doctor, medical facility, dentist or vision facility
- Obtain a claim form from the Fund's Administrative Office
- Complete the claim form and attach the itemized bill to the form
- Send the claim form and bill to the address on the claim form

An itemized bill generally includes all of the following:

- Participant's name and address
- Patient's name and address
- Date of Service
- Type of Service and diagnosis
- Itemized charges
- Provider's complete name, address and tax identification number

Payment for eligible benefits will be made to the health care provider unless your claim includes a paid receipt. If a receipt is submitted with your claim, payment will be sent to you.

A claim is not filed until it is received by Medical Mutual. The Fund's Administrative Office will process your claim within thirty (30) days of the date it is filed unless special circumstances require additional processing time. If additional information is needed to process your claim, the Fund may request additional information from you or the provider. You and/or your physician will have at least 45 days to submit the additional information.

When certain expenses are not eligible under the Fund, you will be notified by the Fund's Administrative Office that the claim is denied in whole or part with an explanation of the reasons for the denial. You will receive a Notice of the Adverse Benefit Determination in writing which contains the following:

- The specific reasons for the adverse benefit determination;

- The specific reference to the Plan and/or Summary Plan Description provisions on which the adverse benefit determination was based;
- A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such materials or information is necessary;
- The notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim; and
- A description of this Fund's Appeals Procedure set forth below.

2. **Prescription claims under Caremark Program**

You will receive a personalized Prescription Benefits Identification Card once you become eligible in this Fund. You must present your Prescription Benefits Identification Card along with your Doctor's prescription to any participating Caremark pharmacy.

The pharmacist will fill the prescription and charge you the co-payment, which is the amount you pay. The pharmacist will generally ask you to sign the form to indicate that you received the prescription. It is permissible for any of your eligible Dependents to present your identification card with a prescription to the pharmacist and sign for receipt of the prescription. This point of sale purchase of a prescription is not a claim for benefits. If you do not receive your prescription at the Caremark retail pharmacy due to a denial of coverage, you need to contact the Administrative Office to make a claim for benefit coverage.

If you elect to have your prescription filled by a pharmacy other than a participating Caremark pharmacy, do not use your Prescription Benefits Identification Card. Follow the Claim Reimbursement Procedure described below to obtain reimbursement of prescription expenses.

You can obtain a Caremark Direct Reimbursement form from the Fund's Administrative Office. You are to complete the top portion. Either have the pharmacist complete the remainder of the form or attach an itemized receipt that includes all of the requested information. Pay the charge for the prescription in full to the pharmacy and mail the completed form to Caremark's address on the form. Reimbursement will be made directly to you by Caremark on the same basis as benefits would have been paid to a participating pharmacy.

If you are not eligible for benefits at the time you contact the Caremark pharmacy or in the event that the prescription is not a covered drug under the Fund, you must contact the Fund's Administrative Office for additional information. The Fund's Administrative Office will review your claim for benefits and if the claim is denied in whole or part, provide you with a Notice of the Adverse Benefit Determination in writing which contains the following:

- The specific reasons for the adverse benefit determination;
- The specific reference to the Plan and/or Summary Plan Description provision on which the adverse benefit determination was based;
- A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such materials or information is necessary;

- The notice of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and
- A description of this Fund's Appeals Procedure set forth below.

3. **How to file a Claim for Vision Benefits**

If you receive services from any vision provider, you may be required to file the claim yourself. Some providers will file the claim on your behalf once you supply them with the information from your identification card.

Itemized bills must contain the following information:

- Name and Social Security Number of the Participant
- Name and address of the provider of service (doctor, hospital, etc.)
- Patient's full name and relationship to Participant
- Date(s) of service
- Description of the services performed on each date or description of the item
- Amount charged for each service/item

Please note: If you have already made payment for the services you received, you must also submit proof of payment with your claim form.

Remember: Canceled checks, cash register receipts or personal itemizations are not acceptable as itemized bills.

You must submit originals of all itemized bills. You should make copies of the itemized bills for your own records. Once your claim is received, itemized bills cannot be returned.

If you have already made payment for the services you received, you must also submit proof of payment with your claim. In the event you do not provide proof of your payment to the provider, the payment from the Fund will be made to the provider directly on your behalf.

A claim is not filed until it is received by the Fund's Administrative Office. They will process your claim within 30 days of the date it is filed unless special circumstances require additional processing time. If additional information is needed to process your claim, the Fund's Administrative Office may request additional information from you or the provider. You and/or your provider will have at least 45 days to submit the additional information.

When certain expenses are not eligible under the Plan, you will be notified by the Fund's Administrative Office that the claim is denied with an explanation of the reasons for the denial. You will receive a Notice of the Adverse Benefit Determination in the form of an Explanation of Benefits (EOB) in writing which contains the following:

- The specific reasons for the adverse benefit determination;

- The specific reference to the Plan and/or Summary Plan Description provisions on which the adverse benefit determination was based;
- A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such materials or information is necessary;
- The notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim; and
- A description of this Fund's Appeals Procedure set forth below.

4. **How to file a claim for Weekly Sickness benefits**

Claims should be submitted to the Fund's Administrative Office as soon as possible; do not delay in filing any claims. Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims. You must obtain a claim form from the Fund's Administrative Office to be completed by you and your treating physician. This documentation should be completed as soon as possible in order to begin receiving your weekly benefits after you complete the waiting period.

The Fund's Administrative Office will make a decision on the claim and notify you of the decision within 45 days. If the Fund requires an extension of time due to matters beyond its control, you will be notified of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 45 day period. A decision will be made within 30 days of the time the Fund's Administrative Office notifies you of the delay.

If the Fund's Administrative Office needs additional information from you to make its decision, you will be notified as to what information must be submitted. You will have at least 45 days to submit the additional information. Once the Fund's Administrative Office receives the information from you, you will be notified of the decision on the claims within 30 days.

In the event that your claim for benefits is denied in whole or part, the Fund's Administrative Office will provide you with a Notice of the Adverse Benefit Determination in writing which contains the following:

- The specific reasons for the adverse benefit determination;
- The specific reference to the Plan and/or Summary Plan Description provision on which the adverse benefit determination was based;
- A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such materials or information is necessary;
- The notice of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and
- A description of this Fund's Appeals Procedure set forth below.

5. **How to file claims for Death and accidental death and dismemberment benefits**

Claims should be submitted to the Fund's Administrative Office as soon as possible; do not delay in filing any claims. Claims for Death, Accidental Death and Accidental Dismemberment benefits will be provided through the Fund's Administrative Office. Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims. This will generally include a death certificate and documentation to establish the death or dismemberment is the result of an accident.

Generally, the Fund's Administrative Office will notify your beneficiary of the decision on the claim for benefits within 90 days. In the event that the Fund's Administrative Office needs additional time to review the claim for benefits or needs additional information, he/she will be provided with the information on the status prior to the expiration of the initial 90 day period.

When the claim for life insurance benefits falls within the Fund's exclusions, your beneficiary will be notified by the Fund's Administrative Office that the claim is denied with an explanation of the reasons for the denial. He/ she will receive a Notice of the Adverse Benefit Determination in writing which contains the following:

- The specific reasons for the adverse benefit determination;
- The sections of the Plan and/or Summary Plan Description upon which the adverse benefit determination was based;
- A description of any additional materials or information necessary for him/her to perfect the claim and an explanation of why such materials or information is necessary;
- The notice of any internal guidelines or protocols used in making the decision, if applicable, and his/her right to receive a copy;
- A notice of his/her right to a written explanation of any exclusion which affects his/her claim, if applicable; and
- A description of the Fund's Appeals procedures set forth below.

6. **Proof of Claims**

Written proof of claims for payment of Covered Services must be furnished as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. **All claims must be submitted by you or the Provider no later than 90 days from the date on which the services were incurred.** Failure to furnish the claim within that time will neither invalidate nor reduce any claim if it is shown that it was not reasonably possible to furnish written proof of the claim within that time period and that written proof was provided as soon as reasonably possible. **However, all claims must be filed within one (1) year from the date the claim was incurred and if they are not submitted, they will be denied as untimely.**

No action at law or in equity shall be brought to recover on your claim prior to the exhaustion of the reasonable claims and appeals procedures set forth in this Section. Additionally, no action shall be brought at all unless brought within three (3) years from the expiration of the time which the proof of claim is required.

7. **Physical Examination**

The Fund at its own expense shall have the right and opportunity to examine an individual for whom benefits are being claimed under this Fund when and so often as the Trustees may reasonably require while a claim is pending. The Trustees have the right to ask for an autopsy in the case of death, provided this is not forbidden by law.

8. **Review Procedure for claims under the Fund**

You or your authorized representative may appeal the decision by the Fund's Administrative Office to deny any claim for medical, dental, vision, weekly indemnity or life insurance/ accidental death and dismemberment benefits in whole or part. Additionally, any point of service purchase of prescription benefits which is not covered at the pharmacy can be appealed through this Review Procedure. If you are not handling your own claim, then an "authorized representative" must be designated in writing to act on your behalf and the extent of the person's authority must be clearly indicated in the authorization.

9. **First Level Review**

You may file a written notice of appeal to the Administrative Manager for the Board of Trustees at any time within 180 days after the mailing of the Notice of Adverse Benefit Determination. The written notice only needs to state your name, address, social security number, phone number, and the fact that you are appealing from the decision of the Fund's Administrative Office, giving the date of the Notice. The Appeal should be addressed as follows:

Administrative Manager
Sheet Metal Workers Local No. 33 Youngstown District
Health and Welfare Fund
33 Fitch Boulevard
Austintown, Ohio 44515

During the appeals process, you will also be afforded access to all relevant information related to your claim for benefits and its denial and may submit written issues and comments pertinent to the appeal. Additionally, you or your representative may submit additional information prior to any determination on your appeal.

If an appeal requires medical judgment, the Administrative Manager shall consult an appropriate health professional and will disclose the identity of such individual to you upon request.

The Administrative Manager will consider your appeal of a claim for payment of services which you already obtained, called a "post-service claim", as soon as possible after receipt of your request. You will be notified of the decision of the Administrative Manager within thirty (30) days of the date the request for a First Level review is received.

In the event that the denial is upheld, you will receive a written Notice which includes the following information:

- The specific reason for the denial;
- The sections of the Plan and/or Summary Plan Description upon which the denial was based;
- A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;

- A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and
- A notice of your right to file a second level appeal to the Benefits Committee of the Board of Trustees.

10. **Second Level Review**

You may file a written notice of appeal to the Benefits Committee for the Board of Trustees at any time within sixty (60) days after the mailing of the Notice of Denial of the First Level Review. The written notice only needs to state your name, address, phone number, social security number and the fact that you are appealing from the decision of the Fund's Administrative Manager, giving the date of the Notice. The Appeal should be addressed as follows:

Benefits Committee
Sheet Metal Workers Local No. 33 Youngstown District
Health and Welfare Fund
33 Fitch Boulevard
Austintown, Ohio 44515

During the appeals process, you will also be afforded access to all relevant information related to your claim for benefits and its denial and may submit written issues and comments pertinent to the appeal. Additionally, you or your representative may submit additional information prior to any determination on your appeal.

If an appeal requires medical judgment, the Benefits Committee shall consult an appropriate health professional and will disclose the identity of such individual to you upon request.

The Benefits Committee will consider your appeal of a claim for payment of services which you already obtained, called a "post-service claim", as soon as possible after receipt of your request. You will be notified of the decision of the Benefits Committee within thirty (30) days of the date the request for a Second Level review is received.

In the event that the denial is upheld, you will receive a written Notice which includes the following information:

- The specific reason for the denial;
- The sections of the Plan and/or Summary Plan Description upon which the denial was based;
- A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and
- A notice of your right to file a lawsuit under ERISA Section 502(a).

The decision of the Benefits Committee for the Board of Trustees is final and binding.

11. **Voluntary Appeal to the Board of Trustees**

Once you have filed your appeal through the two levels of review, you have the right to file a lawsuit in federal court. However, prior to instituting federal court action, you can file a voluntary appeal to the full Board of Trustees. You must file the Notice of

Voluntary Appeal to the Board of Trustees within sixty (60) days of the mailing Notice of Final Decision by the Benefits Committee.

The Appeal should be addressed as follows:

Board of Trustees
Sheet Metal Workers Local No. 33 Youngstown District
Health and Welfare Fund
33 Fitch Boulevard
Austintown, Ohio 44515

The Board of Trustees will review the appeal at their next scheduled quarterly meeting. In the event that the Trustees are unable to address your appeal at their next scheduled meeting, you will be notified that the decision will be delayed and the date of the following meeting at which your appeal will be reviewed. You will receive notice of the decision of the Board of Trustees as soon as possible after the decision is made.

In the event that you file a voluntary appeal with the Board of Trustees:

1. The Fund will not assert a failure to exhaust administrative remedies;
2. The Fund agrees that any Statute of Limitations applicable to pursuing the claim in court will be tolled during the period of the voluntary appeal process;
3. The Fund requires that the voluntary level of appeal is available only after the Claimant has pursued the required appeal(s);
4. You, upon request, shall be provided sufficient information relating to the voluntary level of appeal to enable you to make an informed decision about whether to submit a benefit dispute to this procedure including:
   - A statement that using this procedure will have no effect on your right to receive other benefits under this Fund;
   - A statement that you have the right to have a personal representative with regard to your claim; and
   - A notice of any circumstances which may impair the impartiality of the Board of Trustees.
5. The Fund will not impose any fees or costs on you as part of this voluntary appeal process.

In the event the denial is upheld, you will receive a written notice which includes the following information:

- The specific reason for the denial;
- The sections of the Plan and/or Summary Plan Description upon which the denial was based;
- A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and
- A notice of your right to file a lawsuit under ERISA Section 502(a).

XVI. NOTICE OF PRIVACY PRACTICES

This Section Describes:

1. How medical information about you may be used and disclosed; and
2. How you may obtain access to this information.

1 Purpose of This Notice and Effective Date

The Sheet Metal Workers Local No. 33 Youngstown District Health and Welfare Fund (the "Fund") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- The Fund's uses and disclosures of Protected Health Information (PHI),
- Your rights to privacy with respect to your PHI,
- The Fund's duties with respect to your PHI,
- Your right to file a complaint with the Fund and with the Secretary of the U.S. Department of Health and Human Services, and
- The person or office you should contact for further information about the Fund's privacy practices.

2. Your Protected Health Information

The term "Protected Health Information" (PHI) includes all information related to your past or present health condition that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Fund in oral, written, electronic or any other form.

When the Fund May Disclose your PHI. The Fund Sponsor has amended its Fund Documents to protect your PHI as required by federal law. Under the law, the Fund may disclose your PHI without your consent or authorization in the following cases:

- ***At your request***, the Fund is required to give you access to certain PHI in order to allow you to inspect it and/or copy it.
- ***As required by an agency of the government.*** The Secretary of the Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Fund's compliance with the privacy regulations.
- ***For treatment, payment or health care operations.*** The Fund and its business associates will use PHI without your consent, authorization or opportunity to agree or object in order to carry out:
  - Treatment,
  - Payment, or
  - Health care operations.

Definitions of Treatment, Payment or Health Care Operations	
Treatment is health care.	Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. ***For example***: The Fund may disclose to a treating physical therapist the name of your treating physician so that the physical therapist may ask for your x-rays from the treating physician.
Payment is paying claims for health care and related activities.	Payment includes but is not limited to making coverage determinations and payment. These actions include billing, claims management, subrogation, Fund reimbursement, reviews for medical necessity and appropriateness of care, utilization review and preauthorization. ***For example:*** The Fund tells your doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Fund.
HealthCare Operations keep the Fund operating soundly.	Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business funding and development, business management and general administrative activities. ***For example:*** The Fund uses information about your medical claims to project future benefit costs or to audit the accuracy of claims processing functions.

When the Disclosure of Your PHI Requires Your Written Authorization . The Fund must generally obtain your written authorization before it will use or disclose psychotherapy notes about you from your psychotherapist. However, the Fund may use and disclose such notes when needed to defend itself against litigation filed by you.

Use or Disclosure of Your PHI That Requires You be Given an Opportunity to Agree or Disagree Before the Use or Release. Disclosure of your PHI to family members, other relatives and your close personal friends is allowed under federal law if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care, and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Use or Disclosure of Your PHI for Which Consent, Authorization or Opportunity to Object Is Not Required. The Fund is allowed under federal law to use and disclose your PHI without your consent, authorization or request under the following circumstances:

- When required by law.
- Public health purposes. To an authorized public health authority if required by law or for public health and safety purposes. PHI may also be used or disclosed

if you have been exposed to a communicable disease or are at risk of spreading a disease of condition, if authorized by law.

- Domestic violence or abuse situations. When authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Fund will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.
- Health Oversight activities. To a health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
- Legal proceedings. When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request that is accompanied by a court order.
- Law enforcement health purposes. When required for law enforcement purposes (for example, to report certain types of wounds).
- Law enforcement emergency purposes. For law enforcement purposes including:
  - ◊ identifying or locating a suspect, fugitive, material witness or missing person, and
  - ◊ disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances.
- Determining cause of death or organ donation . When required to be given to a coroner or medical examiner to identify a deceased person, determine a cause of death or other authorized duties. We may also disclose PHI for cadaveric organ, eye or tissue donation purposes.
- Funeral purposes. When required to be given to funeral directors to carry out their duties with respect to the decedent.
- Health or safety threats. When, consistent with applicable law and standards of ethical conduct, the Fund in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
- Workers' compensation programs . When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke your authorization. The right to revoke the authorization can be limited if the covered entity has taken action in reliance of your authorization or if the authorization was obtained as a condition of obtaining insurance.

Other Uses or Disclosures. The Fund may contact you to provide you information about treatment alternatives or other health-related benefits and services that may be of interest to you.

The Fund may disclose protected health information to the sponsor of the Fund for reviewing your appeal of a benefit claims or for other reasons regarding the administration of this Fund. The "Fund Sponsor" of this Fund is the Sheet Metal Workers Local No. 33 Youngstown District Health and Welfare Fund Board of Trustees.

3. **Your Individual Privacy Rights**

You may request the Fund to:

- Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations, or
- Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

The Fund, however, is not required to agree to your request if the Administrative Manager or Privacy Official determines it to be unreasonable.

You Have the Right to Receive Confidential Communications . In addition, the Fund will accommodate an individual's reasonable request to receive communications of PHI by alternative means or at alternative locations where the request includes a statement that disclosure could endanger the individual.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

You May Inspect and Copy PHI. You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Fund maintains the PHI.

The Fund must provide the requested information within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Fund is unable to comply with the deadline. If unable to comply with the above deadline, the Fund will provide you in writing an explanation and a revised date of receipt.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to Fund and the Secretary of the U.S. Department of Health and Human Services.

You Have the Right to Amend Your PHI . You have the right to request that the Fund amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set subject to certain exceptions. See the Fund's Right to Amend Policy for a list of exceptions.

The Fund has 60 days after receiving your request to act on it. The Fund is allowed a single 30-day extension if the Fund is unable to comply with the 60-day deadline. If the Fund denied your request in whole or part, the Fund must provide you with a written denial that explains the basis for the decision. You or your personal representative may

then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of that PHI.

You or your personal representative will be required to complete a form to request amendment of the PHI.

You Have the Right to Receive an Accounting of the Fund's PHI Disclosures . At your request, the Fund will also provide you with an accounting of disclosures by the Fund of your PHI. This accounting period starts as of April 14, 2003 and allows you to request an accounting for up to six years of disclosures after that date. The maximum period of time you can request is six years. Please contact the Fund Office for a complete listing of the contents of an accounting. You should request a copy of the Fund's Accounting for Disclosure Policy.

The Fund has 60 days to provide the accounting. The Fund is allowed an additional 30 days if the Fund gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Fund will charge a reasonable, cost-based fee for each subsequent accounting.

You Have the Right to Receive a Paper Copy of This Notice Upon Request . To obtain a paper copy of this Notice, contact the Privacy Official at the following address:

Privacy Official
Sheet Metal Workers Local No. 33
Youngstown District Health & Welfare Fund
33 Fitch Boulevard
Austintown, OH 44515

Your Personal Representative. You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be a completed, signed and approved Appointment of Personal Representative form. You may obtain this form by calling the Fund Office.

The Fund retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

The Fund will recognize certain individuals as personal representatives without you having to complete an Appointment of Personal Representative form. For example, the Fund will automatically consider spouse's covered under the Fund as the Personal Representatives for each other. Additionally, the Fund will consider a covered parent, guardian, or other person acting *in loco parentis* as the Personal Representative of any dependent covered by the Fund unless applicable law requires otherwise. A parent may act on an individual's behalf, including requesting access to their PHI. Covered Dependents, including your spouse may, however, request that the Fund restrict information that goes to family members as described above at the beginning of Section 3 of this Notice. Additionally, the Fund will automatically consider any person designated under a Power of Attorney which is on file with the Fund as a Personal Representative.

You or your spouse may elect not to have one another as your Personal Representative. You or your spouse must fill out an Opt-out of Personal Representation Form and submit the Form to the Privacy Official. Your covered dependent children also have the right to submit an Opt-out Form if they do not wish to have one or both of their parents as their deemed Personal Representative. All requests are reviewed by the Privacy Official who may deny the requests, especially those based upon State law restrictions.

4. **The Fund's Duties**

Maintaining Your Privacy. The Fund is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with notice of its legal duties and privacy practices.

This notice is effective beginning on April 14, 2003 and the Fund is required to comply with the terms of this notice. However, the Fund reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Fund prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to you and to all past and present participants and beneficiaries for whom the Fund still maintains PHI. This revised notice will be mailed to the covered participant and dependents.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to:

- The uses or disclosures of PHI,
- Your individual rights,
- The duties of the Fund, or
- Other privacy practices stated in this notice.

Disclosing Only the Minimum Necessary Protected Health Information. When using or disclosing PHI or when requesting PHI from another covered entity, the Fund will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment,
- Uses or disclosures made to you,
- Disclosures made to the Secretary of the U.S. Department of Health and Human Services pursuant to its enforcement activities under HIPAA,
- Uses or disclosures required by law, and
- Uses or disclosures required for the Fund's compliance with the HIPAA privacy regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that:

- Does not identify you, and
- With respect to which there is no reasonable basis to believe that the information can be used to identify you.

In addition, the Fund may use or disclose "summary health information" to the Fund Sponsor for obtaining premium bids or modifying, amending or terminating the group health Fund. Summary information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Fund Sponsor has provided health benefits under a group health Fund. Identifying information will be deleted from summary health information, in accordance with HIPAA.

5. **Your Right to File a Complaint with the Fund or the HHS Secretary**
If you believe that your privacy rights have been violated, you may file a complaint with the Fund Privacy Official at the address provided in Section 3.

You may also file a complaint with:

Secretary of the U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

The Fund will not retaliate against you for filing a complaint.

6. **If You Need More Information**
If you have any questions regarding this notice or the subjects addressed in it, you may contact the Privacy Official at the address provided in Section 3:

7. **Conclusion**
PHI use and disclosure by the Fund is regulated by the federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede this notice if there is any discrepancy between the information in this notice and the regulations.

XVII. CONFORMITY WITH STATE STATUTES

If any provision of the Plan is, on the date it takes effect, in conflict with the laws of the state where issued, that provision is amended to conform to the minimum requirements of said laws.

XVIII. TERMINATION OF COVERAGE

Your coverage under this Plan will terminate at the earliest time stated below:

1. When your eligibility terminates, as discussed in the "Eligibility" Section of this Plan.
2. When this Plan is discontinued.

This provision will not apply if you or your dependent has elected continuation of coverage under Public Law 99-272 (COBRA). See COBRA provision.

In addition to the above, the coverage terminates with respect to an individual Dependent:

1. the date the person ceases to be a dependent;
2. the date the dependent coverage under the policy is cancelled;
3. the date you cease to be eligible for dependent coverage;
4. the last day for which you made any required contribution for the coverage; or
5. the date your employee coverage terminates, unless there is provision to continue the coverage.

XIX. CONTINUATION COVERAGE RIGHTS UNDER COBRA

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Administrative Manager.

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Type of coverage. If you choose COBRA continuation coverage, you will be entitled to the same type of coverage that you had before the event that triggered COBRA. This includes Medical, Prescription Drug, Vision, Hearing and Dental Benefits. However, COBRA coverage does not include Death, Accidental Death and Dismemberment or Short Term Disability Benefits.

Cost of coverage. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. The Fund is permitted to charge the full cost of coverage for similarly situated participants and dependents (including both the Fund's share and the participant's share, if any) plus an additional 2%. If the 18-month period of COBRA continuation is extended because of disability, the Fund is permitted to charge the full cost for similarly situated participants and dependents (including both the Fund's share and the participant's share, if any) plus an additional 50% for members of a COBRA family unit that includes the disabled person for the 11-month disability extension period.

Qualifying Events
If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced; or
2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both). Your spouse's becoming entitled to Medicare means that your spouse:
   a. Was eligible for Medicare benefits; and
   b. Enrolled in Medicare (under Part A, Part B, or both).

   The entitlement date is the date of enrollment;

   or
5. You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes entitled to Medicare benefits (under Part A, Part B or both). Your parent-employee's becoming entitled to Medicare means that your parent-employee:
   a. Was eligible for Medicare benefits; and
   b. Enrolled in Medicare (under Part A, Part B, or both).

   The entitlement date is the date of enrollment;
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the Plan as a "dependent child."

When Is COBRA Coverage Available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Administrative Manager has been notified that a qualifying event has occurred.

The Employer Must Give Notice of Some Qualifying Events. The employer must notify the Administrative Manager of the qualifying event when the qualifying event is the end of employment or reduction of hours of employment, death of the employee or the

employee's becoming entitled to Medicare benefits (qualified for and enrolled in coverage under Part A, Part B, or both).

You Must Give Notice of Some Qualifying Events. You must notify the Plan in writing within 60 days after the qualifying event occurs for the other qualifying events of divorce or legal separation of the employee and a spouse or a dependent child's losing eligibility for coverage as a dependent child. You should also let the Plan know of the death of a Member because there may be a delay in the employer knowing of the event and sending notice to the Plan. You must send this notice to:

Sheet Metal Workers Local No. 33 Youngstown District
Health and Welfare Fund
33 Fitch Boulevard
Austintown, Ohio 44515

You may use the enclosed copy of the COBRA Notice Form for Covered Employees and Qualified Beneficiaries to notify the Administrative Manager of these events.

How Is COBRA Coverage Provided?
Once the Administrative Manager receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's entitlement to Medicare benefits (qualified for and enrolled in coverage under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to (qualified for and enrolled in) Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. However, the covered employee's maximum coverage period will be 18 months. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). The employee's COBRA coverage period in this case is 18 months from the termination of employment and is not related to the employee's Medicare entitlement.

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts only for up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended that are explained in the next two paragraphs.

Disability Extension of 18-Month Period of Continuation Coverage. If you or anyone in your family covered under the Plan through COBRA is determined by the Social Security Administration to be disabled and you notify the Administrative Manager in a

timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

You must notify the Plan of the disability within 60 days of the determination of disability by the Social Security Administration and before the end of the 18-month continuation period. If the Social Security Administration later determines that you are no longer disabled, you must notify the Plan of that determination within 30 days of the determination. You must send written notice to:

Sheet Metal Workers Local No. 33 Youngstown District
Health and Welfare Fund
33 Fitch Boulevard
Austintown, Ohio 44515

You should use the attached copy of the COBRA Notice Form for Covered Employees and Qualified Beneficiaries to notify the Fund Office of a disability determination.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage. If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if:

1. The employee or former employee dies,
2. The employee or former employee becomes entitled to Medicare benefits (qualified for and enrolled in coverage under Part A, Part B, or both),
3. The employee or former employee gets divorced or legally separated, or
4. The dependent child stops being eligible under the Plan as a dependent child.

The extension is available only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

You must notify the Plan within 60 days after the second qualifying event occurs. You must send this notice to:

Sheet Metal Workers Local No. 33 Youngstown District
Health and Welfare Fund
33 Fitch Boulevard
Austintown, Ohio 44515

You may use the enclosed copy of the COBRA Notice Form for Covered Employees and Qualified Beneficiaries to notify the Fund Office of these events.

Can You Elect Other Health Coverage Besides Continuation Coverage?
Maintaining eligibility through the Plan's Self-contributions Provisions. If you have become unemployed due to a reduction in the work force, the existing eligibility rules of

the Fund provide you the opportunity to continue your (and your dependents') program of health and life insurance benefits. This coverage is available under the Self-contributions provisions of the Plan and is similar to active coverage, except that to be eligible for this coverage you must:

- Make self-payments in a timely manner, and
- You must have worked for an employer who is still contributing to the Plan.
- Be available for work through the local union and register at least every 30-days with the Local Union.

Self-contributions may be made for a period up to (6) six months if he meets all the self-contributions eligibility requirements.

If your coverage ends under this self-contribution provision, you will be offered additional COBRA continuation coverage at that time.

Alternate Retiree Coverage. Retiree coverage is provided through self-contributions/ hour bank for you until you reach age 65. You may also cover your dependents until the later of the date you reach age 65 or your spouse reaches age 65. Retiree coverage includes the Medical, Dental, Vision, Life AD&D and Prescription coverage. The Fund provides Retirees with $1,500 of Life Insurance coverage.

You should contact the Fund Office to arrange for Retiree coverage. To maintain your eligibility as a retired member of the Plan, the Fund Office must receive your required monthly premium on a monthly basis by the first day of the month. Your monthly check will cover the upcoming month. There is a grace period of 30 days beyond the monthly due date. However, if your check is not received by the Fund Office within the 30-day grace period, your coverage will be canceled.

It is your responsibility to make payment prior to the expiration of the 30-day grace period. You will be offered additional continuation coverage under COBRA once your coverage in the Retiree program is terminated for any reason including non-payment.

If You Have Questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA's website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA's website.)

Keep Your Plan Informed of Address Changes
In order to protect your family's rights, you should keep the Plan's Administrative Manager informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan's Administrative Manager.

Plan Contact Information
Sheet Metal Workers Local No. 33 Youngstown District Health and Welfare Fund
33 Fitch Boulevard
Austintown, Ohio 44515
Telephone: (330) 270-0453
Toll-Free: (800) 589-8041

Sheet Metal Workers Local No. 33 Youngstown District Health and Welfare Fund

Cobra Notice Form for Covered Employees and Qualified Beneficiaries

From: _____ (Enter your name)

Address: _____ (Enter your address)

To: Sheet Metal Workers Local No. 33 Youngstown District
Health and Welfare Fund
33 Fitch Boulevard
Austintown, Ohio 44515

Date: _____

RE: Cobra Notice to Sheet Metal Workers Local No. 33 Youngstown District Health and Welfare Fund

Dear Plan Sponsor:

This letter is to inform you of the following event(s) [Check the event(s) that apply and include and/or attach the requested information]:

❑ My spouse and I have/will become divorced or legally separated.

Date of divorce or legal separation: _____

Names of covered employee (participant) and all qualified beneficiaries (spouse and other dependents): _____

_____

Attach a copy of the decree of divorce or legal separation.

❑ My child will/has ceased to be covered under the Plan as a dependent child of a participant.

Date child has/will no longer be considered a dependent: _____

Name of child: _____

Reason why child is no longer a dependent: _____

(E.g., no longer a student, over age 19 or 23, if your dependent is a full-time student)

❑ I myself and/or my dependents, who are currently receiving COBRA, have a second qualifying event due to an employee's death, entitlement to Medicare, divorce or legal separation or child losing dependent status.

State the qualifying event that applies: _____

Date of the Second Qualifying Event: _____

Attach a certified copy of the death certificate or a copy of the decree of divorce or legal separation.

❑ I myself and/or my dependent have been determined to be disabled by the Social Security Administration.

Name of the Disabled person: _____

Date of the Social Security determination:_____

Attach a copy of the determination letter from the Social Security Administration.

❑ I myself and/or my dependent have been determined to be no longer disabled by the Social Security Administration.

Name of the Disabled person: _____

Date of the Social Security determination:_____

Attach a copy of the determination letter from the Social Security Administration.

If you have any questions about this notice please contact me or [my representative ___ _____(enter the name of your representative, if you have named one to act on your behalf)] at the following telephone number _____.

My current address and that of my dependents is:

_____.

_____.

_____.

Sincerely,

_____

(Signature of Covered Employee or Qualified Beneficiary who is completing this Notice)

_____

(Print Name of Covered Employee or Qualified Beneficiary who is completing this Notice)

XX. BENEFITS FOR PERSONS ELIGIBLE FOR MEDICARE

As required under the Tax Equity and Fiscal Responsibility Act (TEFRA), the Fund will offer to active employees and their covered Dependents, who are over age 65, the same benefits as are available to younger employees and Dependents. The employee may choose to be covered under the Fund's group medical plan. Medicare will then become the secondary provider of coverage.

Employers who provide medical care benefits under a "large group health plan" are the primary providers of coverage for disabled employees (except for End Stage Renal Dialysis beneficiaries) under age 65 and family members of such employees until the disability ends or age 65, provided the person entitled to Medicare is also eligible for and covered by the Employer's Plan.

"Large Group Health Plan" means a plan that covers employees of at least one employer that normally employed at least 100 employees on a typical business day during the previous Calendar year.

XXI. WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under federal law, group health plans, insurers, and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery, effective for the plan year beginning January 1, 1999. In the case of a participant or beneficiary who is receiving benefits under the plan in connection with a mastectomy and who elects breast reconstruction, federal law requires coverage in a manner determined in consultation with the attending physician and the patient for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

This coverage is subject to a Plan's annual deductibles and coinsurance provisions.

XXII. FAMILY AND MEDICAL LEAVE ACT OF 1993

The Family and Medical Leave Act of 1993 (FMLA) was enacted on February 5, 1993 and was effective February 5, 1994. Generally, FMLA requires your employer to provide you with up to 12 weeks of unpaid leave during any 12-month period for specified family and medical reasons, if you are eligible. During this period, your employer must provide health coverage for you on the same terms and conditions that you receive if you continue to work.

To be eligible for leave under FMLA, you must work for the same contributing employer for at least 12 months and for at least 1,250 hours during the 12-month period before the leave begins. Generally, your employer is obligated to provide Family and Medical

leave only if your employer employs 50 or more employees each working day during each of 20 or more work weeks during the current or preceding calendar year.

During the FMLA leave, your employer must make contributions to the Fund on your behalf so that your health coverage will be continued. Federal law requires that you receive continued eligibility.

A covered employer must grant an eligible participant up to a total of 12 work weeks of unpaid leave during any 12-month period for one or more of the following reasons:

- For the birth or placement of a child for adoption or foster care;
- To care for an immediate family member (spouse, child, or parent) with a serious health condition; or
- To take medical leave when the participant is unable to work because of a serious health conditions;
- Eligible employees are entitled to up to twelve (12) weeks of leave because of "any qualifying exigency" arising out of the fact that the spouse, son, daughter, or parent of the employee is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation.
- An eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered service member who is recovering from a serious illness or injury sustained i the line of duty on active duty is entitled to leave up to twenty-six (26) weeks in a single twelve (12) month period to care for the service member. This military care giver leave is available during "a single twelve (12) month period" during which an eligible employee is entitled to a combined total of twenty-six (26) weeks of all types of FMLA leave.

Arrangements will need to be made for participants to pay their share of health insurance premiums while on leave.

Upon return from FMLA leave, a participant must be restored to his or her original job or to an equivalent job. In addition, a participant's use of FMLA leave cannot result in the loss of any employment benefit that the employee earned or was entitled to before using FMLA leave.

Please contact the Fund office if you have any questions regarding your options under the FMLA.

Repayment of Contributions to Employer. If you take a leave under the FMLA and you fail to return to your Employer for any reason after such absence, under the Act your Employer has the right to collect all contributions made on your behalf during such leave of absence. Thus, to insure your continuing coverage under this Plan and to prevent possible repayment of all contributions to your Employer, you should return to work at the end of your leave under the FMLA.

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

ERISA stands for the Employee Retirement Income Security Act which was signed into law in 1974.

This federal law establishes certain minimum standards for the operation of employee benefit plans, including the Sheet Metal Workers Local 33 Youngstown District Health & Welfare Plan. The Trustees of your Plan, in consultation with their professional advisors, have reviewed these standards carefully and have taken steps necessary to assure full compliance with ERISA.

ERISA requires that Plan Participants and beneficiaries be provided with certain information about their benefits, how they may qualify for benefits and the procedures to follow when filing a claim for benefits. This information has already been presented in the preceding pages of this Summary Plan Description.

ERISA also requires that Participants and beneficiaries be furnished with certain information about the operation of the Plan and about their rights under the Plan.

READ THIS SECTION CAREFULLY. Only by doing so can you be sure that you have the information you need to protect your rights and your best interests under this Plan.

1. ERISA provides that all Plan Participants shall be entitled to:
   a. Examine, without charge, at the Fund Office and at other specific locations such as worksites and Union halls, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the public disclosure room of the Pension and Welfare Benefit Administration.
   b. Obtain, upon written request to the Administrative Manager or Board of Trustees, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements and a copy of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrative Manager may make a reasonable charge for the copies.
   c. 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 Annual Report.
   d. Obtain a complete list of employers sponsoring the Plan upon written request to the Administrative Manager which list is available for examination by Participants and Beneficiaries.
   e. In addition, Participants and Beneficiaries may obtain from the Administrative Manager, upon written request, information as to whether a particular employer or employee organization is a sponsor to the Plan and if the employer or employee organization is a plan sponsor, the sponsor's address.

   The people who operate your Plan, called "fiduciaries" of the Plan have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries.
2. In addition to creating right for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan.

3. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit to which you may be entitled, or exercising your rights under ERISA.
4. If you have a claim for a welfare benefit denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. The Plan's Claim Procedures are furnished automatically without charge as a separate document. If you have a claim for benefits which is denied, in whole or in part, you may file suit in a state or federal court after you exhaust your appeal rights.
5. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in Federal Court. In such a case, the court may require the Plan 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 which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a 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 monies, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.
6. If you have any questions about your Plan, you should contact the Plan Administrative Manager or the Board of Trustees. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Trustees, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor or the Pension and Welfare Benefits Administration, whose offices are located at:

U.S. Department of Labor
Employee Benefits Security Administration
1730 K Street, Suite 556
Washington, DC 20006
Tel: (202) 254-7013

Or

U.S. Department of Labor
Employee Benefit Security Administration
1885 Dixie Highway, Suite 210
Ft. Wright, Kentucky 41011-2664
Tel: (606) 578-4680

Or

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

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

XXIV. DEFINITIONS

Ambulatory Surgical Facility - a facility, with an organized staff of physicians, which:

a. has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis;

b. provides treatment by or under the supervision of physicians and nursing services whenever the patient is in the facility;

c. does not provide inpatient accommodations; and

d. is not, other than incidentally, used as an office or clinic for the private practice of a physician or professional other provider.

Complications of Pregnancy - includes the following conditions:

a. when the pregnancy is not terminated, conditions requiring hospital stays which are not directly related to pregnancy but are caused or adversely affected by the pregnancy. These conditions include acute nephritis, nephrosis, cardiac decompensation, pre-eclampsia, missed abortion and similar medically diagnosed conditions; and

b. when the pregnancy is terminated, it includes non-elective Caesarean section, ectopic pregnancy, miscarriage and therapeutic abortion whether or not the abortion is medically necessary.

Confinement or Confined - is being an in-patient using and being charged for the room and board facilities of an institution.

Consultant - a physician or other professional provider as defined who has special knowledge, training and skill related to your injury, illness or disease.

Convalescent Facility -

a. It is a Skilled Nursing Facility, as the term is defined in Medicare, which is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare, except for a Skilled Nursing Facility which is part of a hospital, as defined; or

b. It is an institution which fully meets all of the following tests:

   i. It is operated in accordance with the applicable laws of the jurisdiction in which it is located.

ii. It is under the supervision of a licensed physician, or registered graduate nurse (R.N.) who is devoting full time to such supervision.

iii. It is regularly engaged in providing room and board and continuously provides 24 hour a day skilled nursing care of sick and injured persons at the patient's expense during the convalescent stage of an injury or sickness.

iv. It maintains a daily medical record of each patient who is under the care of a duly licensed physician.

v. It is authorized to administer medication to patients on the order of a duly licensed physician.

vi. It is not, other than incidentally, a home for the aged, the blind or the deaf, a hotel, a domiciliary care home, a maternity home, or a home for alcoholics or drug addicts or the mentally ill.

vii. It is not a hospital, as defined, or part of a hospital.

Covered Expense - means only the following:

a. covered hospital expense;

b. charges by a doctor or psychologist for professional services;

c. charges by a licensed physical therapist;

d. charges by a nurse for private duty nursing care if the covered person is not confined in an institution, but with the limit that no more than $10,000 will be payable each year;

e. charges for these services and supplies:

i. anesthetics and their administration;

ii. x-ray and laboratory tests;

iii. blood and blood plasma not donated or replaced;

iv. oxygen and its administration;

v. casts, splints, braces, trusses or crutches;

vi. rental or radium or radioactive isotopes;

vii. artificial eye or limb but only the first replacement of a natural eye or limb lost while covered hereunder;

viii. rental of durable equipment used solely for medical purposes;

ix. drugs and medicine requiring the prescription of a doctor and injectable insulin;

x. ambulance service in the United States or Canada to or from the nearest hospital equipped to treat the illness.

f. the room and board charges or a newborn child prior to discharge of the mother from the hospital. Charges incurred beyond that period for the child will be a covered expense only if they are provided for premature birth, abnormal congenital conditions, or illness which begins after birth.

A charge for any of the above will be a covered expense only to the extent it is reasonable.

The expense must be incurred on recommendation or approval of a doctor attending the patient; it must be medically necessary; and the provider of service must be acting within the scope of his license.

An expense will be considered incurred when the service or supply is rendered or furnished.

Reasonable - as it applies to charges, means:

a. the usual charge; or

b. the customary charge;

whichever is less.

Usual charge - is the amount a provider most often charges for a given service.

Customary Charge - is the amount charged by a significant number of providers for a given service in statistically similar geographical areas. The location of the provider will be included as one of the areas. The complexity of the services involved will also be considered in determining if a charge is reasonable.

Covered Hospital Expense - charges made by a hospital for:

a. room and board, but not more than standard semi-private rate for a day of confinement in a private room. Room and board charges includes charges for these services: room, meals, general nursing services, housekeeping, accounting, and all other services needed for care of an in-patient; and

b. services and supplies medically required in the care and treatment of the patient other than personal comfort services, such as radio, television, telephone, barber and beauty services.

If the hospital has no semi-private rooms, the standard semi-private rate will be considered to be 80% of the lowest priced private room. If the hospital charges a flat daily rate for all hospital expense, 60% of the daily charge will be considered to be for room and board; but, if the flat rate decreases with the length of confinement, 90% of the lowest daily charge will be considered to be for room and board Hospital admissions may be subject to the Friday/Saturday exclusion provision, shown in the Exclusions and Limitations provision of this Section.

Covered Person - you or your dependents who are covered for medical coverage.

Covered Service - a service or supply shown in this Plan Booklet and given by a Provider for which we will provide benefits.

Custodial Care - care provided primarily for maintenance of the patient or which is designed essentially to assist the patient in meeting his activities of daily living. This does not include care primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury of condition. Custodial care includes but is not limited to:

- help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications not requiring constant attention of trained medical personnel.

Diagnostic Service - a test or procedure performed when you have specific symptoms to detect or monitor your disease or condition. It must be ordered by a physician or other professional provider. These services are limited to the diagnostic services listed in the benefits section.

Doctor - is a medical practitioner licensed to prescribe and administer drugs or to perform surgery. The term also includes a licensed practitioner whose services are required by law to be covered.

Drug Abuse and Alcoholism - a condition diagnosed to be a mental illness and listed under diagnostic code number 303 and 304 of the International Classification of Diseases of the U.S. Department of Health and Human Service (ICD-9-CM, as amended or revised).

Experimental/Investigative - Services, supplies and procedures which require approval by an agency of the U.S. Government which it has not yet received. Experimental treatments, services, and supplies are also those which have progressed to limited human application, but lack wide recognition as proven and effective in clinical medicine. The Trustees shall have authority to determine whether a treatment, service or supply is Experimental or Investigative. The fact that a Physician has prescribed, ordered, recommended, or approved the treatment, service or supply does not in itself make it eligible for payment. Experimental or Investigative treatments, services, and supplies include, but are not limited to the following:

a. laetrile; and

b. BCG, transfer factor and mixed bacterial vaccine administered in combination.

Home Health Care Plan - is a plan for the care and treatment of a person in his home. To qualify, the plan must be established and approved in writing by the attending doctor; and the care and treatment must be provided by a hospital certified to provide home health services or by a certified home health care agency. The plan must consist of one or more of the following:

a. part-time or intermittent home nursing care by or supervised by a registered graduate nurse;

b. part-time or intermittent home aid services which consist mainly of caring for the patient;

c. physical, occupational or speech therapy; and

d. medical supplies, drugs, medications and laboratory examinations which would be covered hospital expense if the patient were hospital confined.

Hospice Care Plan - is a written outline of the care to be provided for the palliation and management of a person's terminal illness developed by or supervised by the attending doctor.

Hospice Facility - is an establishment which may or may not be a part of a hospital and meets these requirements:

a. it is mainly engaged in provided palliative care for the terminally ill 24 hours a day supervised by a doctor or registered nurse;

b. it maintains records of the charges for its services to patients;

c. it provides pre-death and bereavement counseling; and

d. it has met the conditions to participate in the Medicare hospice program.

Hospital - An institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets all of the tests set forth in (a) or (b) or (c) below:

a. It is a hospital accredited by the Joint Commission of Accreditation of Hospitals.

b. It is a hospital, a psychiatric hospital or a tuberculosis hospital as those terms are defined in Medicare, which is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare.

c. It is an institution which fully meets all of the following tests:

   i. It maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified physicians; and

   ii. It continuously provides on the premises 24 hours a day nursing service by or under the supervision of registered graduate nurses;

   iii. It is operated continuously with organized facilities for operative surgery on the premises.

Illness - is a sickness, pregnancy or injury.

Incurred - a charge is considered incurred on the date the covered person receives the service or supply for which the charge is made.

In-Hospital Benefit Period - a period of time beginning when you enter a hospital and ending when you have been out of the hospital or skilled nursing facility for 90 consecutive days.

Medically Necessary (or Medical Necessity) - a service or supply given by a provider that is required to diagnose or treat a condition, illness or injury and which we determine is:

- appropriate with regard to standards of good medical practice;
- not primarily for the convenience of you or a provider; appropriate supply or level of service which can be safely provided to you. When applied to the care of an inpatient, this means that your medical symptoms or condition cannot be safely or adequately provided to you as an outpatient.

Medicare - is a program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended from time to time.

Medicare Approved - a provider that is certified by the United States Department of Health and Human Services to receive payment under the Medicare program.

Mental Illness - a condition diagnosed to be a mental illness and listed within diagnostic code numbers 290 to 302 and 306 to 319, inclusive of the International Classification of

Diseases of the U.S. Department of Health and Human Services (ICD 9-CM, as amended or revised).

Nurse - is a registered graduate nurse (R.N.); a licensed practical nurse (L.P.N.); a licensed vocational nurse (L.V.N.); or a certified nurse midwife.

Other Provider - the following entities which are licensed, where required, and which for compensation from their patients render covered services.

- Professional Other Provider includes only the following:
  - Psychologist
  - Physical Therapist
  - Podiatrist
  - Doctor of Chiropractic Medicine
  - Laboratory (must be Medicare approved)
  - Dentist
- Other Facility Provider includes only the following institutions:
  - Alcoholism Treatment Facility - a facility which mainly provides detoxification and rehabilitation treatment for alcoholism.
  - Day/Night Psychiatric Facility - a facility which is primarily engaged in providing diagnostic services and therapeutic services for the treatment of mental illness only during the day or during the night.
  - Dialysis Facility - a facility which mainly provides dialysis treatment, maintenance or training to patients on an outpatient or home care basis.
  - Drug Abuse Treatment Facility - a facility which provides detoxification and rehabilitation treatment for drug abuse.
  - Home Health Care Agency - a facility which meets the specifications of Chapter 1739 of the Ohio Revised Code, except for the requirement that such institution be operated within the State of Ohio and which:
    - provides skilled nursing and other services on a visiting basis in the covered person's home; and
    - is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending physician.
  - Outpatient Psychiatric Facility - a facility which mainly provides diagnostic services and therapeutic services for the treatment of mental illness on an outpatient basis.
  - Psychiatric Hospital - a facility which is primarily engaged in providing diagnostic services and therapeutic services for the inpatient treatment of mental illness. Such services are provided by or under the supervision of an organized staff of physicians. Continuous nursing services are provided under the supervision of a registered nurse.

Palliative Care - is a course of treatment mainly directed at lessening or controlling pain; it makes no attempt to cure the person's terminal illness.

Physician - a person who is licensed to practice medicine in all its branches, perform surgery and dispense drugs.

Post-Discharge Tests - Follow-up tests performed on you or your Dependent in a hospital after confinement as a resident in-patient provided

a. such tests are ordered by the attending physician prior to the date you or your Dependent is discharged; and

b. such tests are performed within 7 days from the date you or your Dependent is discharged and must be related to same condition for which you or your Dependent was confined.

Pre-Admission Tests - Tests performed on you or your Dependent in a hospital prior to confinement as a resident in-patient provided

a. such tests are related to the performance of scheduled surgery.

b. such tests have been ordered by a duly qualified physician after a condition requiring such surgery has been diagnosed and hospital admission for such surgery has been requested by the physician and confined by the hospital; and

c. you or your Dependent are subsequently admitted to the hospital, or the confinement is canceled or postponed because a hospital bed is unavailable or because here is a change in your or your Dependent's condition which precludes the surgery.

Provider - a licensed hospital, physician, or other provider

Psychologist - Only a person who specializes in clinical psychology and fulfills the requirements specified in item (a) or (b) below, whichever is applicable

a. A person who is licensed or certified as a psychologist by the appropriate governmental authority having jurisdiction over such licenses or certification, as the case may be, in the jurisdiction where such person renders service to you or your Dependent.

b. A person who is a Member of Fellow of the American Psychological Association, if there is no licensure or certification in the jurisdiction where such person renders service to you or your Dependent.

Same Period of Disability - means for an employee, he has not been at work for the employer for two full weeks or for a dependent, the period is separated by less than three months.

Skilled Nursing Facility - a facility other provider which mainly provides inpatient skilled nursing and related services to patients requiring convalescent and rehabilitation care. Such care is given by or under the supervision of physicians. A skilled nursing facility is not, other than incidentally, a place that provides:

a. minimal custodial, ambulatory, or part-time care; or

b. treatment for mental illness, drug abuse and alcoholism or pulmonary tuberculosis.

Totally Disabled (Total Disability) - a condition resulting from disease or injury in which, as certified by a physician:

- you are unable to perform the substantial duties of any occupation or business for which qualified and are not in fact engaged in any occupation for wage or profit; or you are substantially unable to engage in the normal activities of an individual of the same age and sex.

Usual, Customary and Reasonable - An amount measured and determined by comparing the actual charge with the charges customarily made for similar services and supplies to individuals of similar medical condition in the locality concerned.

Year - is a calendar year.

APPENDIX I

SUMMARY OF DENTAL PLAN BENEFITS
OFFERED THROUGH DELTA DENTAL

DELTA DENTAL

DeltaPreferred Option point-of-service USA
Summary of Dental Plan Benefits
For Group#0005846-0331, 0333, 0334
SHEET METAL WORKERS LOCAL NO. 33 YOUNGSTOWN DISTRICT HEALTH & WELFARE FUND

This Summary of Dental Plan Benefits should be read in conjunction with your Dental Care Certificate. Your Dental Care Certificate will provide you with additional information about your Delta Dental plan, including information about plan exclusions and limitations. **In the event that you seek treatment from a dentist that does not participate in any of Delta Dental's programs, you may be responsible for more than the percentage indicated below.**

Control Plan - Delta Dental Plan of Ohio

Benefit Year - January 1 through December 31

Covered Services -	DPO Member Dentist		DeltaPremier or Nonparticipating Dentist	
	Plan Pays	You Pay	Plan Pays	You Pay
Class I Benefits				
Diagnostic and Preventive Services - Used to diagnose and/or prevent dental abnormalities or disease (includes exams, cleanings and fluoride treatments)	80%	20%	80%	20%
Emergency Palliative Treatment - Used to temporarily relieve pain	80%	20%	80%	20%
Radiographs - X-rays	80%	20%	80%	20%
Sealants - Used to prevent decay of pits and fissures of permanent back teeth	80%	20%	80%	20%
Class II Benefits				
Oral Surgery Services - Extractions and dental surgery, including preoperative and postoperative care	80%	20%	80%	20%
Endodontic Services - Used to treat teeth with diseased or damaged nerves (for example, root canals)	80%	20%	80%	20%
Periodontic Services - Used to treat diseases of the gums and supporting structures of the teeth	80%	20%	80%	20%
Relines and Repairs - Relines and repairs to bridges and dentures	80%	20%	80%	20%
Minor Restorative Services - Used to repair teeth damaged by disease or injury (for example, fillings)	80%	20%	80%	20%
Major Restorative Services - Used when teeth can't be restored with another filling material (for example, crowns)	80%	20%	80%	20%
Class III Benefits				
Prosthodontic Services - Used to replace missing natural teeth (for example, bridges and dentures)	80%	20%	80%	20%
Class IV Benefits				
Orthodontic Services (no age limit) - Used to correct malposed teeth (for example, braces)	80%	20%	80%	20%

Customer Service Toll-Free Number: 800-524-0149
www.deltadentaloh.com
December 6, 2007

- The orthodontic age limitations are hereby waived for eligible Subscribers, spouses and dependent children.
- Oral examinations, prophylaxes (cleanings), and fluoride treatment (to age 19) are payable twice per calendar year.
- Bitewing X-rays are payable once per calendar year and full-mouth X-rays are payable once in any five-year period.
- Sealants are only payable for the occlusal surface of first permanent molars to age nine and second permanent molars to age 14. The surface must be free from decay and restorations. Sealants are payable once per tooth per lifetime.
- Composite resin (white) restorations are Covered Services on posterior teeth.
- Porcelain crowns are not Covered Services on posterior teeth.
- Implants and related services are Covered Services.
- People with certain high-risk medical conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.

Having Delta Dental coverage makes it easy for our enrollees to get dental care almost everywhere in the world! You can now receive expert dental care when you're outside of the United States through our Passport Dental program. This program gives you access to the International SOS Assistance (I-SOS) worldwide network of dentists and dental clinics. English-speaking I-SOS operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment - $1,000 maximum per family per calendar year on Class I, II, III and IV Benefits.

Deductible - None.

Waiting Period – Not applicable.

Eligible People - All eligible members as determined by the rules of eligibility of the fund: Active (0331), Early Retiree (0333) and COBRA (Consolidated Omnibus Reconciliation Act of 1985) enrollees (0334).

Also eligible are your legal spouse, your dependent children to their 19th birthdate, and your dependent children to their 25th birthdate if they are a full-time student.

If you and your spouse are both eligible under this contract, you may be enrolled as both a Subscriber on your own application card and as a dependent on your spouse's application card. Your dependent children may be enrolled on both application cards as well. Delta Dental will coordinate benefits.

APPENDIX II

CHANGE OF ADDRESS / BENEFICIARY FORM

ENROLLMENT FORM

IF THIS FORM IS TO CHANGE CURRENT INFORMATION, mark type of change below:

Add dependents _____ Change Address _____ Delete Dependents _____

Change Beneficiary _____

Please complete and return this form to assure enrollment or change is processed. If additional documentation or information is needed, you will be notified:

Local Number: _____

Member Name: _____

Social Security Number: _____

Street Address: _____

City: _____

State & Zip Code: _____

Home Phone Number: _____

County: _____

Date of Birth: _____

Sex: _____

Marital Status: _____

Spouse Name: _____

Date of Marriage: _____

Social Security Number: _____

Date of Birth: _____

Sex: _____

Dependent Name: _____

Relationship to Member: _____

Social Security Number: _____

Date of Birth: _____

Sex: _____

Over

Dependent Name: _____

Relationship to Member: _____

Social Security Number: _____

Date of Birth: _____

Sex: _____

Dependent Name: _____

Relationship to Member: _____

Social Security Number: _____

Date of Birth: _____

Sex: _____

Dependent Name: _____

Relationship to Member: _____

Social Security Number: _____

Date of Birth: _____

Sex: _____

ARE ANY FAMILY MEMBERS COVERED BY ANOTHER GROUP HEALTH PLAN? ____ Yes ____ No

DEATH BENEFIT INFORMATION

Name of Beneficiary _____ Social Security No. _____

Relationship _____

Address _____

Intentionally withholding or falsifying information requested on this questionnaire may result in loss of coverage for you and your dependents.

Member
Signature _____ Date _____

APPENDIX III

AUTHORIZATION FOR DISBURSEMENT FROM MEDICAL REIMBURSEMENT ACCOUNT

SHEET METAL WORKERS LOCAL NO. 33 YOUNGSTOWN DISTRICT HEALTH & WELFARE FUND

Telephone (330) 270-0453
Toll Free 1-800-589-8041

Office Location
33 Fitch Boulevard
Austintown, Ohio 44515

AUTHORIZATION FOR DISBURSEMENT FROM MEDICAL REIMBURSEMENT ACCOUNT

REQUEST FOR REIMBURSEMENT OF MEDICAL EXPENSES

EMPLOYEE NAME _____

ADDRESS _____

_____ PHONE NO. _____

SOCIAL SECURITY NUMBER _____

I am requesting payment for the following charges for which I have not been reimbursed, and for which I have not and will not be claiming a federal income tax deduction:

AMOUNT OF DEDUCTIBLE $_____

AMOUNT OF CO-INSURANCE $_____

VISION CARE (**attach receipts)** $_____

DENTAL CARE (**attach receipts**) $_____

OTHER MEDICAL EXPENSES (**attach receipts)** $_____
(not covered by the Health & Welfare Fund)

SELF PAYMENT BILLING (**attach copy of billing**) $_____

☐ Check here if you elect to have your self-payment remitted directly to your health fund

Please complete the above, attach a copy of your EOB (Explanation of Benefits) from the Health & Welfare Plan where applicable, and receipts showing payments were made for expenses not covered by the Health & Welfare Plan, sign and return this form to:

SHEET METAL WORKERS LOCAL 33 YOUNGSTOWN DISTRICT
HEALTH AND WELFARE FUND
33 Fitch Boulevard
Austintown, Ohio 44515

All expenses submitted for a quarter will be reimbursed in the months of March, June, September and December. For example, claims received during the months of December, January and February will be reimbursed in March. Please call first to check the status of your account before filing large dollar claims and **PLEASE MAKE A COPY FOR YOURSELF OF ALL CHARGES SUBMITTED IN THE EVENT OF LOSS.**

EMPLOYEE SIGNATURE _____ DATE _____

Not valid unless signed and dated by Employee