COLORADO SHEET METAL WORKERS' LOCAL 9
FAMILY HEALTH PLAN

SCHEDULE A BENEFITS

COMBINED
RESTATED PLAN DOCUMENT
AND
SUMMARY PLAN DESCRIPTION

Effective June 1, 2007

This document is a combined Plan and Summary Plan Description for the Colorado Sheet Metal Workers' Local 9 Family Health Plan ("the Plan"). It is effective June 1, 2007, and replaces all previously issued Plan documents and amendments. The Board of Trustees of the Plan reserves the right to amend, modify or discontinue all or part of this Plan, for any or all Participants, whenever in its judgment conditions so warrant.

The benefits described in the booklet are provided directly by the Plan. Life Insurance and Accidental Death and Dismemberment Insurance are underwritten by Union Labor Life Insurance Company and are described in a separate Certificate Booklet, incorporated herein by reference. Dental Benefits are administered by Delta Dental Plan of Colorado and are described in a separate booklet, incorporated herein by reference. In the event of any inconsistency in the Union Labor Life Insurance and AD&D booklet or the Delta Dental Plan of Colorado booklet and the Plan, the terms of the Plan shall prevail.

There is no liability on the Board of Trustees or any individual entity to provide payment over and beyond the amounts in the Fund collected and available for such purpose.

NO VESTED RIGHTS

No Participant, employee or retiree, the spouse of a deceased Participant, or any other person, shall have any vested right to any benefit(s) provided by the Plan.

NO AGENT MAY INTERPRET PLAN

Employer and Union Representatives and individual Trustees are not authorized to furnish any information respecting the Plan's benefits or eligibility requirements. Any questions regarding eligibility or benefits should be sent to the Administrator or to the attention of the full Board of Trustees.

Colorado Sheet Metal Workers' Local 9
Family Health Plan

Mailing address:
P.O. Box 27910
Denver, Colorado 80227-0910
Street address:
7510 West Mississippi, Suite 200
Lakewood, Colorado 80226
Telephone: 303-922-1213, extension 14
or
Toll free 1-888-831-1213

TO ALL PARTICIPANTS:

We are pleased to present you with this combined Plan and Summary Plan Description booklet incorporating revisions to the Plan since the last booklet was printed. This booklet describes:

1. The eligibility provisions governing the Plan,
2. Accident and Sickness Weekly Benefits,
3. Comprehensive Medical Benefits – **Schedule A**
4. Prescription Drug Benefits, and
5. Vision Benefits.

Please remember the Preferred Provider Option offered by the Fund. If a PPO is utilized, both you and the Plan may realize significant savings.

Mines & Associates, P.C. administers the Member Assistance Program (MAP), and all mental health and substance abuse treatment must be provided by and/or authorized through the MAP.

Life Insurance and Accidental Death and Dismemberment Insurance underwritten by Union Labor Life Insurance Company are described in a separate Certificate Booklet, incorporated into this Plan by reference. In the event of any inconsistencies between the booklet and the Plan, the terms of the Plan shall govern.

Dental benefits are administered by Delta Dental Plan of Colorado and are described in a separate booklet, incorporated into this Plan by reference. In the event of any inconsistencies between the booklet and the Plan, the terms of the Plan shall govern.

Due to the various modifications in the Plan, it is important that you and your family become familiar with the benefits to which you may be entitled and the eligibility provisions governing entitlement to those benefits. **Please read this booklet**.

If you have any general questions regarding your eligibility or continuation coverage ("COBRA"), or if you need any forms or additional, specific information, please contact the Administrator at: 303-922-1213, extension 14 or 1-888-831-1213 or at the above address.

In the event you have questions relating to benefits or claim status, please contact the Medical Claims Administrator at: 800-244-6224.

Sincerely,

BOARD OF TRUSTEES

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SECTION I

IMPORTANT INFORMATION

1. SUMMARY OF BENEFITS – SCHEDULE A

This is only a summary and it does not fully describe the benefits payable by the Plan. Plan benefits are determined by looking at all Plan provisions, such as Maximums, Deductibles, description of Covered Charges, Definitions, General Exclusions and Limitations.

See Page 11 for important information on required Pre-Admission Certification.

MEDICAL AND PRESCRIPTION DRUG BENEFITS

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK	NON-NETWORK AREA
Lifetime Maximum *(Including Medical, Prescription Drug and Transplant Benefits)*	$1,000,000		
Calendar Year Maximum *(Does Not Apply to Organ/Tissue Transplant Benefits)*	$250,000		
Additional maximums apply to specific benefits described below.			
Coinsurance Levels	80% of negotiated fees	60% of Reasonable & Customary	70% of Reasonable & Customary
Calendar Year Deductible			
Individual	$500 per person	$500 per person	$500 per person
Family Maximum	$1,500 per family	$1,500 per family	$1,500 per family
Aggregate (In-Network, Out-of-Network and Non-Network combined)	Yes	Yes	Yes
The Deductible does not apply to PPO physician office visit charges, PPO routine/preventive care and PPO emergency room physician charges. The Deductible is applied to Covered Charges only (that is, any amount billed above the Covered Charge cannot be used to satisfy the Deductible).			
Annual Out-of-Pocket Maximum			
Includes Deductible	No	No	No
Includes Copays	No	No	No
Individual	$3,000 per person	$6,000 per person	$4,500 per person
Family Maximum	$6,000 per family	$12,000 per family	$9,000 per family
Physician's Services			
Physician's Office visit			
Non-Medicare Participants	No charge after $25 per office visit Copay	60% after plan Deductible	70% after plan Deductible
Medicare Participants	No charge	60% after plan Deductible	70% after plan Deductible
Surgery Performed In the Physician's Office	80% after plan Deductible	60% after plan Deductible	70% after plan Deductible
Allergy Treatment/Injections	No charge after either the $25 per office visit Copay or the actual charge, whichever is less	60% after plan Deductible	70% after plan Deductible
Allergy Serum (dispensed by the Physician in the office)	No charge	60% after plan Deductible	70% after plan Deductible
Preventive Care			
Routine Preventive Care for Dependent children through age 4 (including immunizations)	No charge	60% after plan Deductible	70% after plan Deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK	NON-NETWORK AREA
Preventive Care (continued)			
*Routine Preventive Care for Employee and Spouse subject to a **$400** maximum per calendar year* (Includes routine mammograms, PSA, Pap smear services)	No charge; no plan Deductible	60% after plan Deductible	70% after plan Deductible
*Dependent children age 5 and older subject to **$150** maximum per calendar year*	No charge; no plan Deductible	60% after plan Deductible	70% after plan Deductible
Immunizations ages 5 through 18	No charge; no plan Deductible	60% after plan Deductible	70% after plan Deductible
Inpatient Hospital - Facility Services	80% after plan Deductible Precertification required	60% after plan Deductible Precertification required	70% after plan Deductible Precertification required
Semi Private Room and Board	Limited to semi-private room negotiated rate	Limited to semi-private room rate	Limited to semi-private room rate
Private Room	Limited to semi-private room negotiated rate	Limited to semi-private room rate	Limited to semi-private room rate
Special Care Units (ICU/CCU)	Limited to negotiated rate	Limited ICU/CCU daily room rate	Limited ICU/CCU daily room rate
Outpatient Facility Services *Operating Room, Recovery Room, Procedure Room and Treatment Room*	80% after plan Deductible Precertification required	60% after plan Deductible Precertification required	70% after plan Deductible Precertificaiton required
Inpatient Hospital Physician's Visits/Consultations	80% after plan Deductible	60% after plan Deductible	70% after plan Deductible
Inpatient Hospital Professional Services *Surgeon, Radiologist, Pathologist, Anesthesiologist*	80% after plan Deductible	60% after plan Deductible	70% after plan Deductible
Multiple Surgical Reduction	Multiple surgeries performed during one operating session result in payment reduction of 50% of charges to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.		
Outpatient Professional Services *Surgeon, Radiologist, Pathologist, Anesthesiologist*	80% after plan Deductible	60% after plan Deductible	70% after plan Deductible
Emergency and Urgent Care Services			
Physician's Office	No charge after the $25 Copay	No charge after $25 Copay (except if not a true emergency, then 60% after plan Deductible).	No charge after $25 Copay (except if not a true emergency, then 70% after plan Deductible).
Hospital Emergency Room (Call CIGNA within 48 hours after admission for admission certification)	ER professional fee - $25 Copay, then 80% $25 Copay waived if admitted	ER professional fee - $25 Copay, then 80% $25 Copay waived if admitted (except if not a true emergency, then 60% after plan Deductible)	ER professional fee - $25 Copay, then 80% $25 Copay waived if admitted (except if not a true emergency, then 70% after plan Deductible)
	ER Facility Fee – 80% after plan Deductible	ER Facility Fee – 60% after plan Deductible (except if not a true emergency, then 60% after plan Deductible)	ER Facility Fee – 70% after plan Deductible (except if not a true emergency, then 70% after plan Deductible)
Urgent Care Facility or Outpatient Facility	80% after plan Deductible	80% after plan Deductible (except if not a true emergency, then 60% after plan Deductible)	80% after plan Deductible (except if not a true emergency, then 70% after plan Deductible)
Ambulance	80% after plan Deductible	80% after plan Deductible (except if not a true emergency, then 60% after plan Deductible)	80% after plan Deductible (except if not a true emergency, then 70% after plan Deductible)

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK	NON-NETWORK AREA
Inpatient Services at Other Health Care Facilities *Skilled Nursing Facility* – 120 days maximum per calendar year *Rehabilitation Hospital and Sub-Acute Facilities* – no maximum *Respite Care* – 8 days lifetime maximum	80% after plan Deductible	60% after plan Deductible	70% after plan Deductible
Laboratory and Radiology Services *MRIs, CAT Scans and PET Scans* *Other Laboratory and Radiology Services* (All charges billed by independent facility) *Outpatient Hospital Facility* *Independent X-ray and/or Lab facility* *Pre-authorization required for diagnostic tests that are expected to exceed $500*	80% after plan Deductible	60% after plan Deductible	70% after plan Deductible
Outpatient Short-Term Rehabilitative Therapy Includes: Cardiac Rehab (no maximum) Physical Therapy and/or Occupational Therapy (60 days combined maximum per calendar year) Speech Therapy - $1,000 per calendar year	No charge after the $25 Copay	60% after plan Deductible	70% after plan Deductible
Chiropractic Services 30 visits maximum per calendar year	No charge after the $25 Copay	60% after plan Deductible	70% after plan Deductible
Home Health Care 100 days up to a maximum of $5,000 per calendar year Other limits apply (see page 63)	80% after plan Deductible	60% after plan Deductible	70% after plan Deductible
Hospice			
Inpatient Services	80% after plan Deductible	60% after plan Deductible	70% after plan Deductible
Outpatient Services	80% after plan Deductible	60% after plan Deductible	70% after plan Deductible
Bereavement Counseling *Services provided as part of Hospice Care*			
Inpatient	80% after plan Deductible	60% after plan Deductible	70% after plan Deductible
Outpatient	80% after plan Deductible	60% after plan Deductible	70% after plan Deductible
Services provided by Mental Health Professional (see page 10)	Covered under Mental Health benefit	Covered under Mental Health benefit	Covered under Mental Health benefit
Maternity Care Services			
Initial Visit to Confirm Pregnancy	No charge after $25 Copay	60% after plan Deductible	70% after plan Deductible
All Subsequent Prenatal and Postnatal Visits, and Physician's Delivery Charges	80% after plan Deductible	60% after plan Deductible	70% after plan Deductible
Midwife $600 maximum	80% after plan Deductible	60% after plan Deductible	70% after plan Deductible
Delivery Facility (Inpatient Hospital, Birthing Center) *Call CIGNA for pre-admission certification for maternity admissions when the Hospital stay lasts or is expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section.*	80% after plan Deductible	60% after plan Deductible	70% after plan Deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK	NON-NETWORK AREA
Abortion *Abortions are excluded, with limited exceptions. (Refer to Page 70, exclusion i.)*	Generally not covered	Generally not covered	Generally not covered
Family Planning Services			
Office Visits (tests, counseling)	No charge after $25 Copay	60% after plan Deductible	70% after plan Deductible
Surgical Sterilization Procedure *for Vasectomy/Tubal Ligation (excludes reversals)*			
Inpatient Facility	80% after plan Deductible	60% after plan Deductible Precertification required	70% after plan Deductible Precertification required
Outpatient Facility	80% after plan Deductible	60% after plan Deductible	70% after plan Deductible
Inpatient Physician's Services	80% after plan Deductible	60% after plan Deductible	70% after plan Deductible
Outpatient Physician's Services	80% after plan Deductible	60% after plan Deductible	70% after plan Deductible
Physician's Office	80% after plan Deductible	60% after plan Deductible	70% after plan Deductible
Coverage for contraceptive drugs and devices are covered under the prescription drug benefits. (Refer to Page 68.)			
Infertility Treatment *Infertility treatment is not covered; however, coverage is provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed and these services will be covered as any other illness.*	Not Covered	Not Covered	Not Covered
Durable Medical Equipment	60% after plan Deductible	60% after plan Deductible	60% after plan Deductible
External Prosthetic Appliances *(Limits on replacements)*	60% after plan Deductible	60% after plan Deductible	60% after plan Deductible
Dental Care Due to a Medical Condition or Injury *Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.*			
Physician's Office	No charge after $25 Copay	60% after plan Deductible	70% after plan Deductible
Inpatient Facility	80% after plan Deductible	60% after plan Deductible Precertification required	70% after plan Deductible Precertification required
Outpatient Surgical Facility	80% after plan Deductible	60% after plan Deductible	70% after plan Deductible
Physician's Services	80% after plan Deductible	60% after plan Deductible	70% after plan Deductible
This benefit is not part of or subject to the provisions of the dental benefits offered through Delta Dental Plan (refer to Page 82 and the separate booklet for dental benefits).			

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK	NON-NETWORK AREA
Bariatric Surgery- *$30,000 lifetime maximum* *Treatment of clinically severe obesity, as defined by the body mass index (BMI) is covered only at approved centers.* *The following are will continue to be specifically excluded:* • *Medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity.* • *Weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.*	**Note**: Covered only at approved centers through the pre-certification process.	Precertification required	Precertification required
Physician's Office	No charge after $25 Copay; 80% after plan Deductible for x-ray/lab if billed by a separate outpatient diagnostic facility such as a hospital	60% after plan Deductible	70% after plan Deductible
Inpatient Facility	80% after plan Deductible Precertification required	60% after plan Deductible Precertification required	70% after plan Deductible Precertification required
Outpatient Surgical Facility	80% after plan Deductible Precertification required	60% after plan Deductible Precertification required	70% after plan Deductible Precertification required
Physician's Services	80% after plan Deductible	60% after plan Deductible	70% after plan Deductible
Prescription Drugs *CIGNA Pharmacy Retail Drug Program Generic Push, Incentive Formulary Plan* *Includes oral contraceptives and contraceptive devices, and smoking cessation*	$5 per 30-day supply for generic drugs $10 per 30-day supply for preferred brand-name drugs $25 per 30-day supply for non-preferred brand-name drugs	$5 per 30-day supply for generic drugs $10 per 30-day supply for preferred brand-name drugs $25 per 30-day supply for non-preferred brand-name drugs	$5 per 30-day supply for generic drugs $10 per 30-day supply for preferred brand-name drugs $25 per 30-day supply for non-preferred brand-name drugs
CIGNA Tel-Drug Mail Order Drug Program *Includes prescription vitamins, oral contraceptives and contraceptive devices*	$10 per 90-day supply for generic drugs $20 per 90-day supply for preferred brand-name drugs $50 per 90-day supply for non-preferred brand-name drugs	In-network coverage only	In-network coverage only

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK	NON-NETWORK AREA
Mental Health and Substance Abuse ***Lifetime equivalent of 40 inpatient days for mental health and substance abuse treatment combined.***	When referred by the MAP, benefits are payable for treatment of mental health or substance abuse for services rendered by a Hospital, Physician, Health Care Practitioner or Licensed Treatment Center. Refer to Page 10 for information regarding the MAP. ***Any treatment which has not been directed or referred by the MAP will not be a covered benefit under the Plan.***		
Inpatient	80% after plan Deductible	60% after plan Deductible	70% after plan Deductible
Outpatient	No charge after $25 Copay	50% after plan Deductible	50% after plan Deductible
Substance Abuse Intensive Outpatient program	No charge after $25 Copay	50% after plan Deductible	50% after plan Deductible
Mental Health/Substance Abuse Service Specific Administration and Case Management	Partial Hospitalization, Residential Treatment and Intensive Outpatient Programs: The following administration will apply: • Partial Hospitalization: Mental Health (MH) and/or Substance Abuse (SA) partial hospitalization services maximum is 50% of the inpatient benefit maximum; e.g., day limits are combined (2:1 ratio). The coinsurance level for partial hospitalization services is the same as the coinsurance level for inpatient MH/SA services. Coverage only if approved through Mines and Associates Case Management. • Standard Option for Residential Treatment: MH and/or SA Residential Treatment at 50% of Inpatient benefit; day limits are combined (2:1 ratio). Coverage only if approved through Mines and Associates Case Management. • Intensive Outpatient Program (IOP): SA Intensive Outpatient Program at 1 to 5. Visit limits are combined with Outpatient Visit limits. Coverage only if approved through Mines and Associates Case Management.		
Organ and Tissue Transplants *Includes all medically appropriate, non-experimental transplants*			
Inpatient Facility	100% at LifeSource center; otherwise 80% after plan Deductible	60% after plan Deductible	70% after plan Deductible
Physician's Services	100% at LifeSource center; otherwise 80% after plan Deductible	60% after plan Deductible	70% after plan Deductible
Travel Services Maximum- only available for LifeSource facilities	$10,000		
		Maximum: *Heart - $150,000* *Liver - $230,000* *Bone Marrow - $130,000* *Heart/Lung - $185,000* *Pancreas - $50,000* *Kidney - $80,000* *Kidney/Pancreas - $80,000*	*Maximum:* *Heart - $150,000* *Liver - $230,000* *Bone Marrow - $130,000* *Heart/Lung - $185,000* *Pancreas - $50,000* *Kidney - $80,000* *Kidney/Pancreas - $80,000*
Inpatient Pre-Admission Certification - *Continued Stay Review required for all inpatient admissions.* *Outpatient surgery prior authorization* *Not required for Medicare eligible Participants* *For more information, see Page11.* *Mental Health and Substance Abuse services must be approved by Mines and Associates.*	Generally Coordinated by Provider	– **Mandatory**: Participant is responsible for contacting CIGNA Healthcare. – Benefits are denied for any admission reviewed by CIGNA Healthcare and not certified. – Benefits are denied for any additional days not certified by CIGNA Healthcare	– **Mandatory**: Participant is responsible for contacting CIGNA Healthcare. – Benefits are denied for any admission reviewed by CIGNA Healthcare and not certified. – Benefits are denied for any additional days not certified by CIGNA Healthcare.

BENEFIT HIGHLIGHTS	IN-NETWORK OUT-OF-NETWORK NON-NETWORK AREA
Case Management (other than Mental Health and Substance Abuse services)	Coordinated by CIGNA Healthcare. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost-effective care while maximizing the patient's quality of life.
Vision Care	100% up to $75 maximum per calendar year per participant (and all family members combined), no Deductible

ACCIDENT AND SICKNESS WEEKLY BENEFITS – EMPLOYEE ONLY

Weekly Benefit.. $210

Benefits Commence: *1st Day Accident; 8th Day Sickness*

Maximum Period Payable.. 13 weeks

DENTAL BENEFITS

Summarized on Pages 82 – 84 or refer to the Delta Dental booklet.

LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS – EMPLOYEE ONLY

Death Benefit $5,000

Accidental Death and Dismemberment $5,000

For a complete description, please refer to the Certificate Booklet from The Union Labor Life Insurance Company.

Please note that capitalized terms are defined in the Definitions section of this booklet.

2. MEMBER ASSISTANCE PROGRAM (MAP)

EXCLUSIVE NETWORK FOR MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT

All mental health and substance abuse treatment must be provided through and/or referred by the MAP. **Any treatment which has not been directed or referred by the MAP will not be a covered benefit under this Plan.**

SERVICES

MAP is a program designed to assist you with various personal problems. During different stages of our lives, we all have personal concerns. MAP can help you during those times. Personal problems can be many and varied.

Following are common areas of concern:

- Adolescent problems
- Alcohol abuse
- Anxiety
- Co-dependency
- Depression
- Drug abuse
- Eating disorders
- Eldercare
- Family problems
- Financial/legal
- Grief/loss
- HIV-Aids related concerns (non-medical)
- Marital problems
- Relationships
- Self esteem
- Stress
- Trauma counseling
- Women's issues (e.g., postpartum depression)
- Work related concerns

All of the above services may not be covered under Comprehensive Medical Benefits. Any care that is transitioned from the MAP session to the medical plan for additional counseling services must be coordinated with the Claims Administrator.

FEES AND APPOINTMENTS

Your MAP sessions (up to five (5) per household member per year) are free for you and your household members. To use your member assistance program for these or any other problems, call the MAP office nearest you. An appointment will be scheduled promptly. Office hours are flexible for your convenience. For emergencies, 24-hour service is available.

There are times when everybody can use help with their problems. The use of these benefits can help you live a better, happier life and be productive.

Keep this booklet handy so you and your family members will have easy access to the MAP phone numbers.

FOR AN APPOINTMENT CALL:

Mines and Associates, P.C. at 1-800-873-7138

3. UTILIZATION MANAGEMENT REVIEW AND REQUIRED PRE-ADMISSION CERTIFICATION

MANDATORY PRE-ADMISSION CERTIFICATION

You, your family or the provider are responsible for contacting CIGNA Healthcare. Benefits are denied for any admission reviewed by CIGNA Healthcare and not certified. Benefits are denied for any additional days not certified by CIGNA Healthcare.

IN-NETWORK – The provider should contact CIGNA on your behalf to obtain pre-certification. However, you are ultimately responsible for obtaining pre-certification and you should check with the provider to make sure he or she has received authorization from CIGNA.

OUT-OF-NETWORK – Pre-admission/Admission certification **is required** for all out-of-network Hospital and Licensed Ambulatory Surgical Facility admissions. CIGNA should be notified of an emergency Hospital admission within 48 hours. **Contact CIGNA HealthCare at 1-800-244-6224.**

Pre-Admission Certification will not apply to Retired Medicare Eligible Participants.

WHAT PARTICIPANTS NEED TO KNOW

To avoid any reduction or denial of benefits a Participant must contact CIGNA HealthCare when any of these events occur:

- NON-EMERGENCY HOSPITAL ADMISSION: Notify CIGNA at least two (2) weeks prior to a non-emergency Hospital admission.
- EMERGENCY NON-PLANNED HOSPITAL ADMISSION: Call CIGNA within 48 hours after admission.
- MATERNITY HOSPITAL ADMISSION: Call CIGNA for Pre-Admission Approval for maternity admissions when the hospital stay lasts or is expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section.
- PRE-AUTHORIZATION DIAGNOSTIC TESTS: Call CIGNA to obtain pre-authorization for diagnostic procedures (e.g., MRIs/CAT Scans) that are expected to exceed **$500**.
- NON-EMERGENCY OUTPATIENT SURGERY: Call CIGNA to obtain pre-authorization for outpatient surgery in a Hospital or Licensed Ambulatory Surgical Facility.

CIGNA HealthCare
1-800-244-6224

TREATMENT FOR MENTAL OR NERVOUS DISORDERS OR SUBSTANCE ABUSE: Call Mines and Associates 1-800-873-7138. All mental and nervous disorders and substance abuse treatment must be provided through or authorized by Mines and Associates.

4. THE BENEFITS OF IN-NETWORK PPO'S

You will receive a higher level of benefits if you utilize the services of the In-Network Preferred Provider Organization, referred to as a PPO. PPO's are those Hospitals, Health Care Practitioners and Physicians with whom the Plan has a discount arrangement. You may obtain a free copy of the list of participating providers from the Administrator; however, because the list may change from time to time, please call the toll-free number shown on the back of your ID card to confirm the list of providers or go to www.cigna.com.

If you are unable to locate an in-network PPO Provider in your area who can provide you with a service or supply that is covered under this Plan, you should call the number on the back of your ID card to obtain authorization for non-participating provider coverage. If you obtain authorization for services provided by a non-participating provider, benefits for those services will be covered at the in-network benefit level rather than the out-of-network benefit level, as shown on the Summary of Benefits.

5. CLAIMS REVIEW AND APPEALS INFORMATION

5.01 HOW TO FILE A CLAIM

Claims should be submitted to the appropriate Administrator as described below.

<table>
<tr><th>Benefit</th><th>Administrator</th></tr>
<tr><td>Accident and Sickness Weekly Benefits

The employee should obtain the proper disability claim form from the Administrator and carefully follow the claim filing instructions on the claim form. All the questions must be answered accurately and completely.

Life Insurance and Accidental Death and Dismemberment Insurance

Written notice of the death, a "Statement of Beneficiary Form," a certified copy of the death certificate and the deceased employee's Social Security number must be submitted to the Administrator. Claims for dismemberment should also be directed to the Administrator.</td><td>Fringe Benefit Services, Inc.
P.O. Box 21240
Denver, CO 80221-0240

Telephone: 303-427-5580</td></tr>
<tr><td>Medical, Prescription Drug and Vision Claims

Present your Plan Identification Card to the in-network provider or hospital and they may file your claim directly with the Plan through CIGNA. If they do not file the claim, or you use an out-of-network provider, you will be responsible for filing the claim. Contact CIGNA or the Administrator for claim forms. Be sure to use your Member ID and account number when you file claim forms or call the CIGNA office. Prompt filing of any required claim form will result in faster payment of your claim.</td><td>CIGNA HealthCare
Open Access Plus – Account #3317508
P.O. Box 182223
Chattanooga, TN 37422-7223

(or if you live in
Nebraska or North Carolina:
P.O. Box 5200
Scranton, PA 18505-5200)

1-800-244-6224</td></tr>
</table>

Dental	Delta Dental
If your Dentist is a participating Dentist of Delta Dental, the claim form will be filed by your Dentist. The patient should complete the patient section of the claim form and sign the form to indicate that he/she authorizes release of the information to Delta Dental. If you elect treatment from a non-participating Dentist, you may be responsible for filing your claim.	A claim form may be downloaded from: www.deltadentalco.com or You may contact Delta Dental at: 303-741-9305 1-800-610-0201 Your group number is 1883

5.02 WHEN CLAIMS MUST BE FILED

Benefits will be paid by the Plan only if written notice of claim is filed within ninety (90) days from the date on which Covered Charges were first incurred, unless it shall be shown by the Participant not to have been reasonably possible to give notice within such time limit, but in no event shall benefits be allowed if written notice of claim is made beyond one (1) year from the date expenses were incurred.

5.03 INFORMATION TO BE REPORTED

It is important that the Administrator be notified whenever a change in any one of the following occurs:

Home Address

Advise the Administrator promptly so their records will be up-to-date if they have to contact you about any matter concerning your benefit coverage.

Beneficiary Designation

Contact the Administrator to obtain the necessary form in the event you wish to change your beneficiary for your Life Insurance Benefit.

Family Composition

Give prompt, written notice to the Administrator about any change in your family, such as marriage or divorce, birth of a child, the marriage of any of your children, the death of any Dependent, or a change in student status for a Dependent child.

Other Items To Report

In addition, you should notify the Administrator if:

a. you are receiving worker’s compensation benefits;

b. you return to work after disability ceases; or

c. you enter or return from military service as defined by the Uniformed Services Employment and Reemployment Rights Act (USERRA).

If a Participant fails to give written notice to the Administrator about any change in the information discussed above, and the Plan pays benefits to which the Participant (or his Dependents) are not entitled, such Participant shall be liable to the Plan for all such erroneous payments and expenses and the Fund may offset such amounts against future benefit payments which would otherwise be due the Participant or his Dependent(s).

ADMINISTRATOR
Mary Martin
P.O. Box 27910
Denver, CO 80227-0910
Telephone: (303) 922-1213, extension 14
1 (888) 831-1213

5.04 CONFIDENTIALITY

The Plan maintains sensitive medical information about you in its files. The Plan keeps this information in strict confidence for your protection and the protection of all participants. You may obtain specific documents from his/her file by making a written request to the Plan Administrator for such documents. However, the Plan reserves the right to keep private all its proprietary information in any file and obtain or release any information necessary to determine the applicability or implementation of any Plan benefit or as permitted or required by the Health Insurance Portability and Accountability Act (HIPAA).

5.05 VERIFYING CHARGES

The Plan was established to provide reimbursement for legitimate medical care costs for Participants, including eligible Dependents. Unfortunately, statements received from providers of care may include charges for services and/or supplies that were not rendered or are inaccurately stated. In order to help control the overall cost of the Fund, by not paying excess charges, your assistance in monitoring such charges would be greatly appreciated. Please assist us by supporting the following review procedures.

When you incur charges for hospital and medical care, please check all charges listed for services on your copy of the Hospital's or Physician's statement. Should you find any charge for services which you cannot verify, please write or call the Claim Administrator immediately. If we do not hear from you, we will assume each service charged has been received by you or your eligible Dependent.

Please be assured that it is not the intent of this review to deny payment for any eligible expense under the Plan. The purpose of the review is to evaluate charges assessed to Participants and determine if any discrepancies exist. The Claims Administrator will follow up on your behalf and notify you of the results. Please refer to Page 79 for a description of the Self-Audit Program and how you can receive a percentage of any recoupment by the Fund of excess payments to providers.

5.06 CLAIMS REVIEW AND APPEALS PROCEDURES

a. All claims for insured benefits shall be filed with, and determined by, the insurance carrier in accordance with its claims and appeals procedures and its agreement with the Plan. For all other benefits from the Plan, the following claims and appeals procedures apply for medical and disability claims.

b. A Participant or beneficiary (collectively "claimant") may name a representative to act on the claimant's behalf during the claims procedure. To do so, a claimant must notify the Plan in writing of the representative's name, address, and telephone number and authorize the Plan to release information (which may include medical information) to a claimant's representative. In the case of an urgent care claim, as defined below, a health care professional with knowledge of a claimant's medical condition will be permitted to act as a claimant's representative. The Plan does not impose any charges or costs to review a claim or appeal; however, regardless of the outcome of an appeal, neither the Board of Trustees nor the Plan will be responsible for paying any expenses that a claimant might incur during the course of an appeal.

c. The Plan and its Board of Trustees, in making decisions on claims and appeals, will apply the terms of the Plan document and any applicable guidelines, rules and schedules, and will periodically verify that benefit determinations are made in accordance with such documents, and where appropriate, are applied consistently with respect to similarly situated claimants.

d. The Plan's procedures and time limits for processing claims and for deciding appeals are described below. The Plan may also request that a claimant voluntarily extend the period of time for the Plan to make a decision on a claim or appeal.

Appeals should be submitted to the appropriate Administrator as described below.

Benefit	**Administrator**
Accident and Sickness Weekly Benefits	Board of Trustees Colorado Sheet Metal Workers' Local 9 Family Health Plan P.O. Box 27910 Denver, CO 80227-0910
Medical, Prescription Drug or Vision Benefits Urgent Care	CIGNA National Appeals 400 Brand Boulevard Glendale, CA 91203 CIGNA 1-800-244-6224
Dental	Delta Dental of Colorado Appeals Analyst P.O. Box 172528 Denver, CO 80217-2528
Life and Accidental Death and Dismemberment Insurance	The Union Labor Life Insurance Company Attn: Group Life Claims 8403 Colesville Road Silver Springs, MD 20910 1-866-795-0680 or 202-682-4697

5.07 CLAIM REVIEW FOR MEDICAL AND DISABILITY BENEFITS

a. PRE-SERVICE CLAIMS

A pre-service claim is any claim for benefits under the Plan, the receipt of which is conditioned, in whole or in part, on the Plan's approval of the benefit before a claimant receives the medical care.

1. If a claimant's pre-service claim is filed improperly, the Plan will notify a claimant of the problem (either orally or in writing, unless a claimant requests it in writing) within five (5) days of the date a claimant filed the claim.

2. The Plan will notify a claimant of its decision on a claimant's pre-service claim (whether approved or denied) within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after the claim is received by the Plan. The Plan may extend the period for a decision for up to fifteen (15) additional days due to matters beyond the control of the Plan, provided that the Plan gives a claimant a written notice of such extension before the end of the initial fifteen (15) day period. The notice of an extension will set forth the circumstances requiring an extension of time and the date by which the Plan expects to make a decision. If an extension is necessary due to a claimant's failure to submit the information required to decide the claim, the notice of extension will specifically describe the required information, and a claimant will be given at least forty-five (45) days from receipt of the notice to provide the requested information.

3. If a claimant does not provide the information requested, or does not properly refile the claim, the Plan will decide the claim based on the information it has available, and the claim may be denied.

b. URGENT CARE CLAIMS

An urgent care claim is a pre-service claim that requires shortened time periods for making a determination where the longer time periods for making non-urgent care determinations (i) could seriously jeopardize a claimant's life or health or a claimant's ability to regain maximum function or (ii) in the opinion of a Physician with knowledge of a claimant's medical condition, would subject a claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

1. If a claimant's urgent care claim is filed improperly, the Plan will notify a claimant of the problem (either orally or in writing, unless a claimant request it in writing) within twenty-four (24) hours of the date a claimant filed the claim.

2. The Plan will notify a claimant of the decision on a claimant's urgent care claim (whether approved or denied) as soon as possible, taking into account the medical exigencies, but not later than within seventy-two (72) hours after the claim is received by the Plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. If the Plan needs more information, the Plan will notify a claimant of the specific information necessary to complete the claim as soon as possible, but not later than twenty-four (24) hours after receipt of the claim by the Plan. A claimant will be given a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the requested information. The Plan will notify a claimant of its decision as soon as possible, but not later than forty-eight (48) hours after the earlier of (i) the Plan's receipt of the specified information or (ii) the end of the

period given to a claimant to provide the specified information. Due to the nature of an urgent care claim, a claimant may be notified of a decision orally, which will be followed by a written notice of the same information within three (3) days of the oral notice.

3. If a claimant does not provide the information requested, or does not properly refile the claim, the Plan will have to decide the claim based on the information it has available, and the claim may be denied.

c. CONCURRENT CARE CLAIMS

A concurrent care claim is a request for the Plan to approve, or to extend, an ongoing course of treatment over a period of time or number of treatments, when such approval is required by the Plan. If a claimant has been approved by the Plan for concurrent care treatment, any reduction or termination of such treatment (other than by Plan amendment or termination of the Plan) before the end of the period of time or number of treatments will be considered denial of a claim.

1. The Plan will notify a claimant of the denial of the claim at a time sufficiently in advance of the reduction or termination to allow a claimant to appeal and obtain a decision on review of the denial of the claim before the benefit is reduced or terminated.

2. A claimant's request to extend a course of treatment beyond the previously approved period of time or number of treatments that constitutes an urgent care claim will be decided as soon as possible, taking into account medical circumstances, and will be subject to the provisions of these procedures for urgent care claims, except the Plan will notify a claimant of the decision (whether approved or denied) within twenty-four (24) hours after the Plan's receipt of the claim, provided that the claim is made to the Plan at least twenty-four (24) hours before the end of the previously approved period of time or number of treatments.

d. POST-SERVICE CLAIMS

A post-service claim is any claim under the Plan that is not a pre-service claim.

1. If the Plan denies a claimant's post-service claim, in whole or in part, the Plan will send a claimant a notice of the claim denial within a reasonable period of time, but not later than thirty (30) days after the claim is received by the Plan. The Plan may extend the period for a decision for up to fifteen (15) additional days due to matters beyond the control of the Plan, provided that the Plan gives a claimant a written notice of such extension before the end of the initial thirty (30) day period. The notice of an extension will set forth the circumstances requiring an extension of time and the date by which the Plan expects to make a decision. If an extension is necessary due to a claimant's failure to submit the information required to decide the claim, the notice of extension will specifically describe the required information, and a claimant will be given at least forty-five (45) days from receipt of the notice to provide the requested information.

2. If a claimant does not provide the information requested, the Plan will decide the claim based on the information it has available, and the claim may be denied.

e. ACCIDENT AND SICKNESS (DISABILITY)

1. If the Plan denies a claimant's claim for Accident and Sickness benefits, in whole or in part, the Plan will send the claimant a notice of the denial within a reasonable period of time, but not later than forty-five (45) days after the claim is received by the Plan. The Plan may extend the period for a decision for up to thirty (30) additional days due to matters beyond the control of the Plan, provided that the Plan gives the claimant a written notice of such extension before the end of the initial forty-five (45) day period. The notice of an extension will set forth the circumstances requiring an extension of time and the date by which the Plan expects to make a decision. The Plan may also extend the period for a decision for up to a second extension of thirty (30) additional days due to matters beyond the control of the Plan, provided that the Plan gives the claimant a written notice of such extension before the end of the first thirty (30) day extension period. The notice of an extension will set forth the circumstances requiring an extension of time and the date by which the Plan expects to make a decision. In addition, any notice of an extension will set forth the circumstances requiring an extension of time, an explanation of the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve these issues.
2. If an extension is necessary due to a claimant's failure to submit the information required to decide the claim, the claimant will be given at least forty-five (45) days from receipt of the notice to provide the requested information. If a claimant does not provide the information requested, the Plan will decide the claim based on the information it has available, and the claim may be denied.

f. DENIAL IN WHOLE OR IN PART

If the Plan denies a claimant's claim for medical or disability benefits, in whole or in part, the Plan will send the claimant a written notice of the denial, unless, as provided above, a claim is for urgent care, then this notice may be oral, followed in writing. The notice will provide:

1. the specific reason or reasons for denial;

2. reference to specific Plan provisions on which the denial is based;

3. a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;

4. an explanation of the Plan's claims review procedures and the time limits applicable to such procedures, including the expedited review process applicable to urgent care claims;

5. a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following a denial of a claimant's appeal;

6. if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying a claim, a statement that the specific rule, guideline, protocol, or other similar criterion was relied upon in denying the claim and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request; and

7. if the denial is based on a determination of medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment related to a claimant's condition will be provided free of charge upon request.

5.08 APPEAL PROCEDURES

a. A claimant may appeal a denial of a benefit claim to the Plan's Board of Trustees. The appeal must be in writing; however, an appeal of an urgent care claim may also be made orally. The appeal should be sent to the Administrator listed on page 16, who will forward it to the Board of Trustees.

b. If a claimant's claim for medical, prescription drug, dental, vision or disability benefits has been wholly or partially denied, the claimant will have one hundred eighty (180) days from receipt of the denial notice to file an appeal with the Plan's Board of Trustees.

c. A claimant has the right:

   1. to submit written comments, documents, records, and other information relating the claim for benefits; and

   2. upon request, reasonable access to, and free copies of, all documents, records, and other information relevant to the claim for benefits.

d. In making a decision on review, the Board of Trustees or a committee of the Board of Trustees will review and consider all comments, documents, records, and all other information submitted by a claimant or a claimant's duly authorized representative, without regard to whether such information was submitted or considered in the initial claim determination. In reviewing a claim, the Board of Trustees will not automatically presume that the Plan's initial decision was correct, but will independently review a claimant's appeal. In addition, if the initial decision was based in whole or in part on a medical judgment (including a determination whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the Board of Trustees will consult with a healthcare professional in the appropriate medical field who was not the person consulted in the initial claim (nor a subordinate of such person) and will identify the medical or vocational experts who provided advice to the Plan on the initial claim.

e. In the case of an appeal of a claim involving urgent care as defined above, the Board of Trustees will notify a claimant of the decision on the appeal as soon as possible, taking into account the applicable medical exigencies, but not later than seventy-two (72) hours after the Plan 's receipt of the appeal.

f. In the case of an appeal of a pre-service claim as defined above, the Board of Trustees will notify the claimant of the decision on the appeal within a reasonable period of time appropriate to the medical circumstances, but not later than thirty (30) days after the Plan's receipt of the appeal.

g. In the case of a post-service claim or disability claim, the Board of Trustees or a committee of the Board of Trustees will hear a claimant's appeal at their next scheduled quarterly meeting following receipt of a claimant's appeal, unless a claimant's appeal was received by the Plan within thirty (30) days of the date of the meeting. In that case, a claimant's appeal will be reviewed at the second quarterly meeting following receipt of the appeal. If special circumstances require an extension

of the time for review by the Trustees, a claimant will be notified in writing, before the extension, of the circumstances and the date on which a decision is expected. In no event will a decision be made later than the third quarterly meeting after receipt of a claimant's appeal. The Trustees will send the claimant a written notice of their decision (whether approved or denied) within five (5) days of the decision.

h. If the Board of Trustees has denied a claimant's appeal, the notice will provide:

1. the specific reason or reasons for the denial;

2. references to specific Plan provisions on which the denial is based;

3. a statement that a claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; and

4. a statement of a claimant's right to bring an action under Section 502(a) of ERISA.

In addition, the notice will state that:

1. if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying an appeal, a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request; and

2. if the denial of a claimant's appeal was based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation will be provided free of charge upon request.

i. The Board of Trustees has the power and sole discretion to interpret, apply, construe and amend the provisions of the Plan and make all factual determinations regarding the construction, interpretation and application of the Plan. The decision of the Board of Trustees is final and binding.

j. The claimant must exhaust the administrative remedies herein by appealing the denial of a benefit claim to the Board of Trustees before the claimant has the right to file suit in state or federal court under Section 502(a) of the Employee Retirement Income Security Act ("ERISA"), and failure to exhaust these administrative remedies shall result in the loss of the claimant's right to file suit. In no event shall any action be brought more than two (2) years from the date of the Board of Trustees' decision on an appeal.

SECTION II

ELIGIBILITY AND BENEFITS

.

1. DEFINITIONS

1.01 **<u>Active Employee</u>**. "Active Employee" means any employee who meets the Eligibility Rules in section 2.01 (Pages 32-41).

1.02 **<u>Administrator</u>**. "Administrator" means the person, firm, organization, and/or company designated by the Board of Trustees to handle the administrative responsibilities of the Plan, other than eligibility certification and claims payment. The term "Administrator" does not have the same meaning as "Plan Administrator" under ERISA. The Plan Administrator is the Board of Trustees.

1.03 **<u>Board of Trustees</u>**. "Board of Trustees" means the individuals jointly named as fiduciaries, as established by the Trust Agreement, or their successor and successors.

1.04 **<u>Claims Administrator</u>**. "Claims Administrator" means the person, firm and/or company designated by the Board of Trustees to handle the eligibility certification and payment of benefits provided by the Plan.

1.05 **<u>Concurrent Review</u>**. "Concurrent Review" means the review of the confinement while a Participant is confined in a facility as an inpatient. The review of the continued stay in the facility is coordinated with the Physician, the facility and the review coordinator for determining whether the care or course of treatment that is proposed is Medically Necessary and reasonable care. The review is designed to eliminate unnecessary treatment or unneeded, prolonged confinements.

1.06 **<u>Continuation Coverage</u>**. "Continuation Coverage", for purposes of section 2.04 (Pages 44-54) means coverage provided by any source other than contemporaneous contributions, including hour bank, SASMI or self-payment.

1.07 **<u>Contributing Employer</u>**. "Contributing Employer" means any employer who is required by a collective bargaining agreement or other written agreement with the Union to make contributions to the Fund. The term "Contributing Employer" shall also include the Union, if it makes contributions to the Fund on behalf of its employees, provided the inclusion of said Union is not a violation of any existing law or regulations.

1.08 **<u>Copayment/Copay</u>**. "Copayment" or "Copay" means the amount a Participant must pay for a specified service.

1.09 **<u>Covered Charges</u>**. "Covered Charges" means Usual, Customary and Reasonable Charges for Medically Necessary services and supplies. A Covered Charge is incurred at the time a service is rendered or other item is provided for which a charge is made and falls within the description of Covered Charges set forth in section 4.05 (Pages 59-66) and section 5.04 (Pages 67-68).

1.10 **<u>Covered Employment</u>**. "Covered Employment" means employment of an Active Employee by a Contributing Employer.

1.11 **<u>Creditable Coverage</u>**. "Creditable Coverage" means with respect to an individual any of the following:

a. A group health plan;

b. Health insurance coverage;

c. Part A or Part B of Title XVIII of the Social Security Act;

d. Title XIX of the Social Security Act rather than coverage consisting solely of benefits under Section 1928;

e. Chapter 55 of Title XX, United States Code;

f. A Medical Care Program of the Indian Health Services or of a Tribal Organization;

g. A State Health Benefits Risk Pool;

h. A Health Plan offered in Chapter 89 of Title V, United States Code;

i. A Public Health Plan (as described in regulation promulgated under Subtitle B of Title I of ERISA); or

j. A Health Benefit Plan under Section 5(e) of the Peace Corps Act (22 U.S.C. §2504(e)).

The term "Creditable Coverage" does not include coverage consisting solely of coverage of excepted benefits as defined in Section 706 of ERISA.

1.12 **Custodial Care**. "Custodial Care" means any care intended primarily to help a Participant meet basic personal needs; such care is to maintain the Participant's present state of health and when

a. there is no plan of active medical treatment to reduce the disability or improve a medical condition to a great extent; or

b. the plan of active medical treatment cannot reasonably be expected to reduce the disability or improve a medical condition to a great extent.

1.13 **Deductible**. "Deductible" means the amount a Participant must incur for Covered Charges during a calendar year before benefits are payable, as set forth in section 4.02 (Page 57).

1.14 **Dependent**. "Dependent" means:

a. the Eligible Employee's lawful spouse.

b. the Eligible Employee's unmarried natural or adopted children who:

1. receive over one-half their support from the Eligible Employee;
2. have the same residence as the Eligible Employee for at least one-half the year; and
3. are less than nineteen (19) years of age or less than twenty-four (24) years of age provided they are full-time students at an institution of higher learning.

Dependent children also include:

1. an unmarried foster or stepchild who meets the age and support requirements above and resides with the Eligible Employee;
2. an unmarried child who meets the age requirement above, but not the residency requirement (for example, in the case of divorce), provided the Eligible Employee provides over one-half the child's support (or otherwise meets the support requirements for a dependent under Internal Revenue Code Section 152);
3. an unmarried child under age nineteen (19) as required by the terms of a Qualified Medical Child Support Order within the meaning of Section 609(a) of ERISA; and

4. an unmarried child who is incapable of self-sustaining employment by reason of mental or physical handicap, provided such incapacity commenced prior to the limiting age and the child is dependent upon the Eligible Employee for support and maintenance. Notification and proof of such incapacity must be submitted to the Administrator within thirty-one (31) days of the date the Dependent child's coverage would otherwise terminate.

Adopted children are covered as of the date of adoption or the placement of the child for adoption with the Eligible Employee in connection with adoption proceedings.

Dependent does not include an emancipated minor or an individual who is also an Eligible Employee. A child shall in no event be an eligible Dependent of more than one (1) Eligible Employee.

If there are questions about whether a child qualifies as a Dependent under the Plan, please contact the Administrator.

1.15 **Durable Medical Equipment**. "Durable Medical Equipment" means medical equipment not otherwise excluded, that is designated for repeated use, that is primarily and customarily used to serve a medical purpose, and is not useful to a person in the absence of illness or injury. Examples of Durable Medical Equipment include, but are not limited to wheelchairs, hospital beds and respirators, but do not include items such as air conditioners, humidifiers, dehumidifiers, air purifiers, cold therapy units and other similar items.

1.16 **Eligible Employee**. "Eligible Employee" means each Active Employee, Non-Bargaining Employee or Self-Pay Employee as set forth in sections 1.01, 1.32 or 1.52 herein. It also includes an employee entitled to continued participation pursuant to the Family and Medical Leave Act, 29 U.S.C. §2602 et. seq. and the Colorado Adoptive Parents Leave Act, C.R.S. §19-5-211.

1.17 **Fund**. "Fund" means the Colorado Sheet Metal Workers' Local 9 Family Health Plan as established by the Trust Agreement.

1.18 **Health Care Practitioner.** "Health Care Practitioner" means a behavior health practitioner, Chiropractor, Podiatrist, Dentist, Optometrist, Physician Assistant, Nurse Practitioner, Nurse, midwife, Occupational, Physical, Respiratory or Speech Therapist or Speech Pathologist, or Master's prepared Audiologist who is licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his/her license and/or scope of practice; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient. See also the definition of Physician and Physician Assistant/Nurse Practitioner.

1.19 **Home Health Care**. "Home Health Care" means service rendered to a Participant in a private residence by or through an organization or agency which meets the requirements for participation as a home health agency under Medicare. Home Health Care services are described in section 4.05, n. (Page 63).

1.20 **Home Health Visit**. "Home Health Visit" means each visit by a member of a home health team, provided on a part-time and intermittent basis as included in the plan of care. Services for up to four (4) hours by a home health aide shall be considered as one (1) visit.

1.21 **Hospice Benefit Period**. "Hospice Benefit Period" means the period that begins on the date the Physician certifies that the Participant is a Terminally Ill Patient and ends six (6) months after it began or on the death of the Participant, if sooner. If the Hospice Benefit Period ends before the death of the Participant, a new Hospice Benefit Period may begin if the Physician again certifies that the Participant is a Terminally Ill Patient.

1.22 **Hospice Care**. "Hospice Care" means palliative and supportive medical, health care and other services provided by a hospice agency to Terminally Ill Patients to meet special physical and emotional needs as part of dying so that a hospice patient may remain at home, to the maximum extent possible, with home-like inpatient care utilized only if and while it is necessary. Hospice Care includes care received as an inpatient in a hospice facility or section of a Hospital which provides such care. A hospice agency must be licensed by the appropriate state agency and meet the certification requirements under Medicare.

1.23 **Hospital**. "Hospital" means an institution operated pursuant to law which is primarily engaged in providing (for compensation from its patients) medical, diagnostic, therapeutic and surgical facilities for the care and treatment of sick and injured persons on an inpatient basis, and which provides such facilities under the supervision of a staff of Physicians and with twenty-four (24) hour-a-day nursing service by registered nurses (R.N.). Emergency and surgical services provided under a contract with another licensed Hospital will be considered to be provided by such institution. In no event, however, shall such term include any institution, or part of one which is used principally as a rest facility, nursing facility, convalescent facility, facility for the aged, facility for the chronically ill, or providing Custodial Care, Maintenance Care, or educational care.

To the extent that benefits are provided, a facility approved under the laws of the governing jurisdiction of this Plan for the treatment of mental or nervous disorders will be considered a Hospital with respect to benefits for such treatment.

1.24 **Intensive Care Unit or Coronary Care Unit**. "Intensive Care Unit or Coronary Care Unit" means a section or wing within the Hospital which is operated for critically ill patients and provides special supplies, equipment and supervision and care by a registered nurse (R.N.) or other trained Hospital personnel.

1.25 **Licensed Ambulatory Surgical Facility**. "Licensed Ambulatory Surgical Facility" means a place which maintains and operates facilities for surgery and surgical diagnosis and treatment on an open panel basis by persons licensed to practice medicine and surgery in all its branches, licensed to practice podiatry or licensed to practice dentistry or oral surgery, which shall have an attending medical staff consisting of one (1) or more anesthesiologists or a nurse anesthetist under the supervision of a licensed Physician or surgeon. This term shall not mean a Hospital, extended care facility, nursing or convalescent home, home for the needy, home for the nursing and domiciliary care of children of pre-school age, infirmary or orphanage, private sanitarium, private office or clinic of licensed health care, mental health facility, home or institution, or any other facility which exists for the purpose of providing health care services.

1.26 **Licensed Treatment Center**. "Licensed Treatment Center" means a treatment center licensed by the state of its situs as a facility providing treatment of substance abuse.

1.27 **Maintenance Care**. "Maintenance Care" means care which is provided solely to maintain the patient's condition at the level to which it has been restored where no significant practical improvement can be expected.

1.28 **Medical Emergency**. "Medical Emergency" means a sudden and unexpected condition requiring, in the opinion of a Physician, immediate medical-surgical or Hospital care or both, to prevent death or serious impairment of the health of the affected Participant. Medical Emergency includes heart attacks, severe injuries, poisonings, loss of consciousness or respiration, convulsions and such other acute conditions as a medical authority shall determine to be a Medical Emergency.

1.29 **Medically Necessary**. "Medically Necessary" means a service or supply which is appropriate and consistent with the diagnosis of a particular condition, in accordance with accepted standards of community practice, and could not have been omitted without adversely affecting the person's condition or the quality of medical care.

1.30 **Medicare**. "Medicare" means the benefits provided under Title XVIII of the Social Security Act of 1965, and as amended from time to time.

1.31 **Member Assistance Program (MAP)**. "Member Assistance Program (MAP)" means the program approved by the Board of Trustees, as amended from time to time, whereby a Participant may obtain counseling for mental or nervous disorders and/or substance abuse problems. In the case of mental or nervous disorders and/or substance abuse problems, any inpatient or outpatient services must be authorized by the MAP in advance. If advance authorization is not received from the MAP, Plan benefits will not be payable.

1.32 **Non-Bargaining Employee**. "Non-Bargaining Employee" means any employee who meets the Non-Bargaining Participation provisions in section 2.02.

1.33 **Non-Preferred Provider Organization or Non-PPO**. "Non-Preferred Provider Organization or Non-PPO" means any provider who has not contracted with the Plan's contracted Preferred Provider Organization or with the Plan directly to provide Covered Charges described in section 4.05 (Pages 59-66) or 5.04 (Pages 67-68).

1.34 **Non-PPO Service Area**. "Non-PPO Service Area" means geographical areas outside the PPO Service Area.

1.35 **Occupational Therapy**. "Occupational Therapy" means the use of education, vocational, and rehabilitative techniques to improve a patient's functional ability to live independently.

1.36 **Outpatient Precertification**. "Outpatient Precertification" means the prior written authorization that must be obtained from the precertification coordinator or other organization designated by the Board of Trustees, for care or treatment performed on an outpatient basis in a Licensed Ambulatory Surgical Facility, for outpatient surgery in a Hospital, for comprehensive diagnostic services over $500, and for outpatient MRI and Cat Scan review.

1.37 **Participant**. "Participant" means:

a. an Eligible Employee.

b. an Eligible Employee's Dependents.

c. Qualified Beneficiaries.

1.38 **Physical Therapy**. "Physical Therapy" means the use of physical agents to treat a disability resulting from disease or injury. Physical agents include, but are not limited to heat, cold, electrical currents, ultrasound, ultraviolet radiation, therapeutic massage, and therapeutic exercise.

1.39 **Physician**. "Physician" means a person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) and authorized to practice medicine, to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his/her license and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

1.40 **Physician Assistant/Nurse Practitioner**. "Physician Assistant or Nurse Practitioner" means an individual who is qualified by academic and clinical training to provide primary care patient services under the supervision and responsibility of a Physician, and must be certified by the state. Physician Assistants and Nurse Practitioners who are employees of the Physician are payable under the Plan if rendering covered services.

1.41 **Plan**. "Plan" means those health and welfare benefits described herein, as provided by the Colorado Sheet Metal Workers' Local 9 Family Health Plan.

1.42 **Plan Year**. "Plan Year" means January 1 to December 31 of any year.

1.43 **Pre-Admission Certification**. "Pre-Admission Certification" means the prior written authorization that must be obtained from the pre-certification coordinator or other organization designated by the Board of Trustees, for all planned inpatient confinements, including emergency or maternity admissions. Pre-Admission Certification must be obtained within two weeks before the start of planned confinements and within forty-eight (48) hours after any emergency/non-planned admission.

1.44 **Preferred Provider Organization or PPO**. "Preferred Provider Organization or PPO" means any plan recognized provider corporation organization or entity which has contractual arrangements with the Plan to provide Covered Charges.

With respect to the treatment of mental or nervous disorders and substance abuse, Preferred Provider means only those Hospitals, free-standing facilities, Physicians and Health Care Practitioners when authorized and referred by the MAP.

1.45 **PPO Service Area**. "PPO Service Area" means the geographical area in which a PPO is available.

1.46 **Qualified Beneficiary**. "Qualified Beneficiary" for purposes of COBRA continuation coverage, section 2.04 of this Plan is:

a. Any individual who, on the day before a Qualifying Event as defined herein, is covered under this Plan by virtue of being on that day either an Eligible Employee or a Dependent of an Eligible Employee; or

b. Any child who is born to, adopted by, or placed for adoption with an Eligible Employee during a period of COBRA Continuation Coverage.

1.47 **Qualifying Event.** "Qualifying Event" means with respect to any Eligible Employee or Dependent of an Eligible Employee, any of the following events which, but for the COBRA continuation coverage provided under section 2.04 would result in the loss of coverage to the Eligible Employee or Dependent:

a. The death of the Eligible Employee;

b. The voluntary or involuntary termination (other than by reason of gross misconduct), or reduction in hours of the Eligible Employee's employment (all referred to hereinafter as a "Qualifying Event affecting employment");

c. The divorce or legal separation of the Eligible Employee from the employee's spouse;

d. A Dependent child's ceasing to be a Dependent child of an Eligible Employee.

A loss of coverage need not occur immediately after the event, so long as the loss of coverage occurs before the end of the maximum coverage period set forth in section 2.04, but COBRA

coverage periods are measured from the occurrence of the Qualifying Event.

1.48 **Rehabilitation Facility.** "Rehabilitation Facility" means a facility that is recognized by the Plan and licensed or certified to perform rehabilitative health care services by the state or jurisdiction where services are provided. Services of such a facility must also be among those covered by the Plan.

1.49 **Respite Care.** "Respite Care" means care that is furnished to a Terminally Ill Patient when confined as an inpatient so the family unit may have relief from the stress of the care of the Participant.

1.50 **Restatement Effective Date.** "Restatement Effective Date" means June 1, 2007.

1.51 **SASMI.** "SASMI" means the Stabilization Agreement of the Sheet Metal Industry.

1.52 **Self-Pay Employee.** "Self-Pay Employee" means any active, retired, or disabled employee who has lost eligibility and who is participating in the Plan pursuant to an Extension of Continuation Coverage under section 2.04, d.

1.53 **Self-Pay Participant.** "Self-Pay Participant" means any Self-Pay Employee or a Dependent of a Self-Pay Employee.

1.54 **Skilled Nursing Facility.** "Skilled Nursing Facility" means a lawfully operated institution for the care and treatment of persons convalescing from a sickness or injury which provides room and board and twenty-four (24) hour nursing service by licensed nurses and is under the full-time supervision of a legally qualified Physician or a registered nurse (R.N.). It is not, other than incidentally, a place of rest, a place for Custodial Care, a place for the aged, a place for drug addicts, a place for alcoholics, a place for training the physically or mentally handicapped, a hotel or similar institution.

1.55 **Terminally Ill Patient.** "Terminally Ill Patient" means a Participant whose Physician certifies that such Participant is a Terminally Ill Patient and who is expected to live six (6) months or less.

1.56 **Totally Disabled/Total Disability.** "Totally Disabled" and "Total Disability" mean an Active Employee is disabled as a result of accidental bodily injury or sickness and is therefore prevented from performing his/her occupation with respect to Accident and Sickness Weekly Benefits described in Section 3, on Page 55.

1.57 **Trust Agreement.** "Trust Agreement" means the Agreement and Declaration of Trust establishing the Colorado Sheet Metal Workers' Local 9 Family Health Plan dated July 6, 1962, as modified or amended.

1.58 **Union.** "Union" means the Local Union No. 9 of the Sheet Metal Workers' International Association.

1.59 **Usual, Customary, and Reasonable (UCR) Charges**. "Usual, Customary and Reasonable Charges" means the allowed amount for Medically Necessary services or supplies and will be determined by the Claims Administrator to be the lowest of:

a. With respect to a PPO Provider, the fee set forth in the agreement between the PPO Provider and the PPO or the Plan (sometimes referred to as the "allowed amount"); or

b. For medical benefits, no more than the 80th percentile of a schedule of prevailing health care charges as determined by the Claims Administrator; or

c. The health care provider's actual charge; or

d. The usual charge by the health care provider for the same or similar service or supply.

The "Prevailing Charge" of most other health care providers in the same or similar geographic area for the same or similar health care service or supply will be determined by the Claims Administrator using proprietary data this is provided by a reputable company or entity and is updated no less frequently than annually.

The Plan will not always pay benefits equal to or based on the health care provider's actual charge for health care services or supplies, even after a Participant has paid the applicable Deductible and coinsurance. This is because the Plan covers only the Usual, Customary and Reasonable Charge for health care services or supplies.

Any amount in excess of the UCR Charge does not count toward the Plan's out-of-pocket maximums. Participants are responsible for amounts that exceed UCR allowances payable by this Plan.

1.60 Vocational Rehabilitation. "Vocational Rehabilitation" means teaching and training, which allows an individual to resume his previous job or to train for a new job.

2. ELIGIBILITY RULES

2.01 Eligibility Rules for Active Employees.

a. General Provisions. No medical examination is required to become covered under this Plan. Active Employees will be eligible for coverage if they perform Covered Employment, provided sufficient contributions are made on their behalf by Contributing Employers.

The following rules have been designed in an effort to make certain that all employees working in Covered Employment on a more or less regular basis will continue to remain eligible if they are employed a nominal number of hours each year. The following rules make it possible to count all contribution hours received on behalf of an employee over a full twelve (12) month period for the purpose of continuing eligibility.

b. Presently Eligible Employees. An Active Employee eligible on the Restatement Effective Date, will continue to remain eligible until he/she is terminated in accordance with the provisions of subsection d. (Continued Eligibility) or subsection e. (Termination of Eligibility) of this section 2.01.

c. Initial Eligibility.

1. Employees first performing work in Covered Employment on or after January 1, 2007, may become eligible on the first day of the second calendar month immediately following any six (6) **or less** consecutive calendar month period in which they have been credited with at least six hundred (600) hours of contributions in the aggregate. Hours do not need to be worked in each month during the period. (For employees who first began performing work in Covered Employment before January 1, 2007, the rules in the 2004 Plan, as amended, shall apply.)

In order that there will be sufficient time for Contributing Employer reports to be received and processed, a lag month will be used in determining an Active Employee's eligibility date. The lag month is the month between the report period (the hours on which contributions are reported) and the first month of coverage.

EXAMPLES with a lag month:

EXAMPLE 1

	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Hours worked	145	150	150	150	145	Lag month				
Eligible for							Month of Dec			

In the above example, the employee is eligible for December coverage because more than 600 hours were worked in 5 consecutive months.

EXAMPLE 2

	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Hours worked	150	150	150	150	Lag month					
Eligible for						Month of Nov				

In the above example, the employee is eligible for November coverage because 600 hours were worked in 4 consecutive months.

EXAMPLE 3

	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb
Hours worked	110	120	130	120	0	120	Lag month		
Eligible for								Month of Jan	

In the above example, the employee is eligible for January coverage because 600 hours were worked in 6 consecutive months.

EXAMPLE 4

	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Hours worked	90	90	70	70	80	80	150	150	Lag month	
Hours dropped for							June	July		
Eligible for										Month of Mar

In the above example, the employee is eligible for March coverage because 600 hours were worked in 6 consecutive months (August through January).

Employees not actively at work, due to disability, on the date on which their eligibility would otherwise become effective, will not be eligible for Accident and Sickness Weekly Benefits until they return to active employment. Eligibility for all other benefits will become effective on the normal effective date as if the employee were actively at work.

2. An Active Employee who first performs work in Covered Employment on or after March 1, 2000 and before November 1, 2001 and becomes eligible, shall, after having three thousand (3,000) hours of contributions received, in the aggregate, within twenty-four (24) consecutive months, be eligible until he/she is terminated in accordance with the provisions determined under section 2.01, e.

   An Active Employee who loses eligibility shall again become eligible for coverage only upon completion of the Initial Eligibility stated in section 2.01, c., 1.

3. Retired employees who return to work under section 10.13 of the Rules and Regulations of the Sheet Metal Workers Local No. 9 Pension Trust and who were self-paying under section 2.04, i., 1. will continue to self-pay at the rate currently applicable to them unless and until they establish eligibility under section 2.01, c., 1. Contributions received on their behalf prior to establishing eligibility will be credited to establish eligibility in accordance with section 2.01, c.

4. Retired employees who return to work under section 10.13 of the Rules and Regulations of the Sheet Metal Workers Local No. 9 Pension Trust and who were not self-paying under section 2.04, d., 1. will only be provided coverage in accordance with section 2.01, c., 1.

d. Continued Eligibility. Once eligible, an Active Employee will continue to remain eligible for at least three (3) months, except as provided in paragraph e. below (Termination of Eligibility). Contribution hours from all Contributing Employers are counted; therefore, if an Active Employee moves from one (1) Contributing Employer to another, his/her eligibility will be continued, provided he/she works the total number of hours specified.

e. Termination of Eligibility.

1. Termination Dates. An Active Employee's eligibility will terminate on any of the four (4) termination dates shown below, unless he/she has the required hours of contributions as set out below:

   (a) **On March 31**
   Unless he/she has aggregate contributions of:

   Three hundred (300) hours for the preceding three (3) month period of December, January and February, or

   Six hundred (600) hours for the preceding six (6) month period of September through February, or

   Nine hundred (900) hours for the preceding nine (9) month period of June through February, or

   One thousand two hundred (1,200) hours for the preceding twelve (12) month period of March of the preceding year through February of the current year.

   (b) **On June 30**
   Unless he/she has aggregate contributions of:

Three hundred (300) hours for the preceding three (3) month period of March, April and May, or

Six hundred (600) hours for the preceding six (6) month period of December through May, or

Nine hundred (900) hours for the preceding nine (9) month period of September through May, or

One thousand two hundred (1,200) hours for the preceding twelve (12) month period of June of the preceding year through May of the current year.

(c) **On September 30**
Unless he/she has aggregate contributions of:

Three hundred (300) hours for the preceding three (3) month period of June, July and August, or

Six hundred (600) hours for the preceding six (6) month period of March through August, or

Nine hundred (900) hours for the preceding nine (9) month period of December through August, or

One thousand two hundred (1,200) hours for the preceding twelve (12) month period of September of the preceding year through August of the current year.

(d) **On December 31**
Unless he/she has aggregate contributions of:

Three hundred (300) hours for the preceding three (3) month period of September, October, and November, or

Six hundred (600) hours for the preceding six (6) month period of June through November, or

Nine hundred (900) hours for the preceding nine (9) month period of March through November, or

One thousand two hundred (1,200) hours for the preceding twelve (12) month period of December of the preceding year through November of the current year.

2. Termination Date for Active Employee who Performs Work for Non-Contributing Employer.

(a) An Active Employee's eligibility will terminate on the last day of the month in which the employee first performs work for a non-Contributing Employer for which contributions would be owed if the employer were a Contributing Employer. The normal termination dates in paragraph e., 1. above, and any extension of eligibility under that paragraph do not apply to an employee performing work for a non-Contributing Employer.

(b) Subsection (a) shall not apply if the employee, pursuant to written authorization by the Union, has accepted the employment with the non-Contributing Employer for purposes of organizing. Whether or not such employment is for purposes of organizing shall be determined at the discretion of the Board of Trustees.

(c) An Active Employee whose eligibility is terminated under this sub-section 2. shall not be entitled to an extension of continuation coverage under the self-pay provisions of section 2.04 after the expiration of any applicable COBRA period.

(d) An Active Employee whose eligibility has been terminated under this subsection 2. shall again become eligible for coverage only upon completion of the Initial Eligibility and/or Reinstatement of Eligibility requirements.

f. Reinstatement of Eligibility. If an Active Employee's eligibility is terminated because of his/her failure to perform the necessary minimum hours of work on which contributions are received, or is terminated as described in subsection e., 1. or 2., or a Retired Employee's coverage is terminated under 2.04, d., 1. he/she may be reinstated as follows:

1. on the first day of the first calendar month immediately following loss of eligibility provided the Fund has received on his/her behalf contributions equal to one hundred (100) hours of work and the Active Employee (or Retired Employee under section 2.04, d., 1.) continued coverage under the Self-Payment Provisions for Continuation Coverage during the month eligibility was lost; or

2. if the above requirement is not met, on the first day of the first calendar month which follows the completion of any three (3) consecutive calendar months for which the Fund has received on his/her behalf contributions equal to three hundred (300) hours of work, provided his/her eligibility, including consecutive periods of self-payment, was not terminated for a period of more than six (6) consecutive calendar months. (A Retired Employee must maintain continuous eligibility on a self-pay basis under section 2.04, d., 1. to be eligible for reinstatement under this section.)

If a period of six (6) consecutive calendar months (excluding periods of self-payment) elapse between an employee's last Termination of Eligibility and his/her Reinstatement of Eligibility, he/she will again be required to meet the eligibility requirements pertaining to Initial Eligibility.

g. New Contributing Employers. Employees who have been eligible under a Contributing Employer's company plan in accordance with provisions of the collective bargaining agreement and who are establishing coverage under the Fund, will be subject to the following provisions:

1. an employee will be eligible on the first day of the calendar month immediately following loss of eligibility under the company plan;

2. an employee will remain eligible provided the Fund receives monthly contributions equal to one hundred (100) hours of work on behalf of such employee;

3. an employee will not accumulate hours as described in section 2.01, c. during the first twelve (12) months following the initial eligibility date. After completion of twelve (12) months, the employee will be credited with three (3) months of coverage. Continuation of coverage will then be determined in accordance with subsection d. Continued Eligibility and subsection e. Termination of Eligibility.

Employees becoming eligible hereunder may be required to provide documentation of prior coverage and comply with other administrative procedures as requested by the Board of Trustees.

h. Continued Eligibility During Disability Periods. If, after an Active Employee becomes eligible and he/she is unable to perform work because of a "certified disability", he/she will be credited, for the purpose of maintaining eligibility, with twenty-five (25) disability hours for each full week of such disability, up to thirteen (13) weeks per calendar year. A "certified disability" is one which commenced while the Active Employee is employed in Covered Employment and for which the Active Employee is entitled to draw Accident and Sickness Weekly Benefits through the Fund or submits evidence that he/she is drawing weekly worker's compensation benefits.

i. Family and Medical Leave Act (FMLA). Active Employees shall be entitled to benefits under the Plan during a family or medical leave in accordance with the provisions of the Family and Medical Leave Act of 1993, as may be amended.

Contributing Employers will be required to pay on the basis of eight (8) hours per day, up to a maximum of forty (40) hours per week while an such employee is on an approved absence under the terms of the Family and Medical Leave Act of 1993.

j. Waiver of Initial Eligibility Requirements with Respect to Employees of a Newly Organized Participating Employer. The Plan may waive its initial eligibility requirements with respect to employees of a newly organized Contributing Employer who were actively working on the date that the employer first had a contribution obligation. The effect of this waiver shall be as follows:

1. The newly organized Contributing Employer may make an initial contribution equal to one hundred sixty (160) hours at the Fund's current contribution rate, on all employees covered under the collective bargaining agreement. This initial contribution will provide the first month's coverage.

2. The newly organized Contributing Employer shall make contributions on all covered employees based on actual hours worked during the first month of participation. Such hours shall be used for the purpose of establishing the second month's eligibility. Thereafter, and for the first twelve (12) months of contributions, this pattern shall be followed. If the newly organized Contributing Employer does not elect to utilize the provision of subparagraph 1. hereof, then initial eligibility shall be in accordance with this subparagraph. Excess hours will not be credited to the employees' quarterly eligibility bank.

3. In the event the employee who has established eligibility under this subsection j. fails to earn at least one hundred (100) hours in any subsequent month of his/her employment with a newly organized Contributing Employer, his/her eligibility will be terminated in accordance with section 2.01, e. and he/she shall be eligible to continue coverage in accordance with section 2.04 Self-Payment Provisions for Continuation Coverage.

4. This waiver of initial eligibility provision shall apply where an employee remains in the employment of a Contributing Employer.

5. This provision shall apply only to those employees who were employed by the newly organized Contributing Employer on the employer's effective date of participation. Employees employed after the employer's initial effective date of participation shall be subject to the Initial Eligibility requirements in section 2.01, c.

6. Active Employees covered under a collective bargaining agreement with a Contributing Employer and subject to this provision will have their eligibility terminated at the end of the month following the date such Contributing Employer elects to withdraw from participation in the Colorado Sheet Metal Workers' Local 9 Family Health Plan whether or not such employer maintains a collective bargaining agreement with the Union, unless the Active Employee makes reasonable efforts to seek and then accepts the first offered employment with another Contributing Employer who continues to pay into this Plan.

7. Active Employees attaining eligibility under this provision may not accumulate more than three hundred (300) hours during their initial twelve (12) months of participation in the Fund. At the end of twelve (12) months of participation, or the end of the next calendar quarter following twelve (12) months if not coincident, employees will be eligible for the next calendar quarter provided they have at least three hundred (300) hours in their bank as the result of work in covered employment. Such three hundred (300) hours may also be utilized during the first twelve (12) months of initial eligibility to maintain eligibility in the event of termination, layoff or discharge. Eligibility following this time period will be based on the eligibility provisions for all other Active Employees.

8. Upon termination, an employee who initially acquired eligibility through employment with a newly organized Contributing Employer may maintain continuous eligibility by continuing contributions either through self-pay, as otherwise provided herein, or through employment with another Contributing Employer. Such an employee may also maintain eligibility through the use of the three hundred (300) hour bank provided for in this section.

k. Reciprocity Agreements. The Board of Trustees may enter into reciprocity agreements with other health funds, whereby eligibility may be continued for a bargaining employee working out of the jurisdiction of the local Union, provided contributions are made to the Colorado Sheet Metal Workers' Local 9 Family Health Plan in accordance with the provisions of the reciprocity agreements.

l. Schedule A and Schedule B Coverage and Transfers.

1. Initial Eligibility. The plan of benefits under Schedule A or Schedule B to which an Active Employee is initially entitled is determined by the contribution rate applicable to Schedule A or Schedule B. The initial eligibility period under section 2.01, c. applies to determine initial eligibility in the Family Health Plan for either the Schedule A or Schedule B plan of benefits. If the Active Employee transfers to an employer unit covered under a different contribution rate, the following provisions apply.

2. Transfer from Schedule B to Schedule A. In the event an Active Employee is covered under the Schedule B plan of benefits and transfers to an employer

unit that is covered under the Schedule A plan of benefits, such Active Employee will be covered under the Schedule A plan of benefits on the first day of the month after six (6) consecutive months in which he/she has been credited with a total of at least six hundred (600) hours of contributions by the Schedule A employer. The Active Employee will remain covered under the Schedule B plan of benefits until such time as he/she meets the eligibility requirements of the Schedule A plan of benefits under this paragraph, provided he/she remains eligible for participation in the Family Health Plan under sections 2.01, d. and e.

3. Transfer from Schedule A to Schedule B. In the event an Active Employee is covered under the Schedule A plan of benefits and transfers to an employer unit that is covered under Schedule B plan of benefits, such Active Employee will be covered under the Schedule B plan of benefits on the first day of the month after six (6) consecutive months in which he/she has been credited with a total of at least six hundred (600) hours of contributions by the Schedule B employer. The Active Employee will remain covered under the Schedule A plan of benefits until such time as he/she meets the eligibility requirements of the Schedule B plan of benefits under this paragraph, provided he/she remains eligible for participation in the Family Health Plan under sections 2.01, d. and e.

4. Deductibles and Maximums upon Transfer. An Active Employee who transfers from the Schedule B plan of benefits to the Schedule A plan of benefits, or from the Schedule A plan of benefits to the Schedule B plan of benefits, must satisfy the Deductibles and maximums applicable to the new plan of benefits. The dollar amount of all Deductibles and maximums accumulated under the prior plan of benefits (either Schedule A or Schedule B) will be applied toward the Deductibles and maximums applicable during the calendar year under the new plan of benefits.

   An Active Employee who transfers from the Schedule B plan of benefits to the Schedule A plan of benefits and who has met the Deductibles and/or maximums under Schedule B shall be deemed to have met the Deductibles and/or maximums under Schedule A for the same calendar year but will not be entitled to any refund or other credit for any amount by which the Schedule A Deductibles and/or maximums have been exceeded.

   An active Employee who transfers from the Schedule A plan of benefits to the Schedule B plan of benefits and who has met the Schedule A Deductibles and/or maximums under Schedule A will have such Deductibles and/or maximums applied to the Schedule B Deductibles and/or maximums for the same calendar year, but payment of benefits under Schedule B will be subject to satisfaction of the additional Schedule B Deductibles and/or maximums.

5. COBRA and Self-Pay after Transfer. An Active Employee who loses eligibility for coverage under section 2.01, e. and is eligible for continuation coverage under section 2.04 (e.g., COBRA, USERRA or retiree self-pay), shall be eligible for such continuation coverage only under the plan of benefits (Schedule A or Schedule B) under which he or she was covered at the time he or she lost coverage under the Plan. If a participant returns to covered employment after being in self-pay status (e.g., COBRA, USERRA or retiree), he or she will be eligible for reinstatement as provided in section 2.01, f. with coverage under the appropriate plan of benefits (Schedule A or Schedule B) according to the contribution rate that applies to the participant on his or her return to covered employment.

EXAMPLES:

SCHEDULE B TO SCHEDULE A ELIGIBILITY

Mike works for an employer under a collective bargaining agreement requiring contributions at the Schedule B level. Mike is covered under the Schedule B plan of benefits. On May 31, 2006 Mike terminates employment with that employer. On June 1, 2006 Mike starts work for an employer under an agreement requiring contributions at the Schedule A level. Mike continues to work enough hours to maintain his eligibility under the Plan's hour bank. On August 2, 2006 Mike is hospitalized. His benefits for that hospitalization, including Deductibles and Copays, will be at the Schedule B level.

By December 1, 2006 Mike has worked for 6 months and 600 hours for his new employer. He would now be eligible for Schedule A benefits. On December 3, 2006 Mike is again hospitalized. His medical claims for the December 3rd services will be paid at the Schedule A level. By that time he had already applied $600 toward the Schedule B Deductible of $750 (individual) for 2006, so he will be considered to have met the Schedule A Deductible, which is only $500 (for an individual) for 2006.

SCHEDULE A TO SCHEDULE B ELIGIBILITY

Joe works for an employer under a collective bargaining agreement requiring contributions at the Schedule A level. Joe is covered under the Schedule A plan of benefits. On May 31, 2006 Joe terminates employment with that employer. On June 1, 2006 Joe starts work for an employer under an agreement requiring contributions at the Schedule B level. Joe continues to work enough hours to maintain his eligibility under the Plan's hour bank. On August 2, 2006 Joe is hospitalized. His benefits for that hospitalization, including Deductibles and Copays, will be at the Schedule A level.

By December 1, 2006 Joe has worked for 6 months and 600 hours for his new employer. He would now be eligible for Schedule B benefits. On December 3, 2006 Joe is again hospitalized. His medical claims for the December 3rd services will be paid at the Schedule B level. By that time he had already met the Schedule A Deductible of $500 (individual) for 2006, which will be applied to the Schedule B Deductible of $750 (individual) for 2006. He will still have to meet the additional $250 Schedule B Deductible before he is eligible for payment of benefits under Schedule B for the December 3rd services.

SCHEDULE B CONTINUES BASED ON NOT MEETING SCHEDULE A INITIAL ELIGIBILITY REQUIREMENTS

John works for an employer under a collective bargaining agreement requiring contributions at the Schedule B level. John is covered under the Schedule B plan of benefits. On May 31, 2006 John terminates employment with that employer. On June 1, 2006 John starts work for an employer under an agreement requiring contributions at the Schedule A level. John continues to work enough hours to maintain his eligibility under the Plan's hour bank.

On September 30, 2006 John is laid off from the Schedule A employer. On October 1, 2006 John goes to work for an employer under an agreement requiring contributions at the Schedule B level. John's benefits never change during the time period discussed in this example. He remains under Schedule B because he did not work under Schedule A for 6 months and 600 hours.

COBRA UNDER SCHEDULE A TO REINSTATEMENT UNDER SCHEDULE B

Sue works for an employer under a collective bargaining agreement requiring contributions at the Schedule A level. Sue is covered under the Schedule A plan of benefits. On May 31, 2006 Sue is laid off. She subsequently loses her eligibility under the Plan's hour bank and elects COBRA coverage starting October 1, 2006, under the Schedule A plan of benefits. On December 1, 2006 Sue goes to work for an employer under an agreement requiring contributions at the Schedule B level. Sue is reinstated in the Plan under the Schedule B plan of benefits in accordance with the reinstatement provisions of the Plan.

2.02 Non-Bargaining Participation.

a. Employer Participation.

1. In order to participate on behalf of Non-Bargaining Employees, Contributing Employers must make application to the Board of Trustees for Non-Bargaining Participation. An application must be completed for each company requesting participation.

   The Board of Trustees reserves the right to accept or reject any Contributing Employer's application for non-bargaining participation.

2. If a Contributing Employer's non-bargaining participation has been approved by the Board of Trustees, the Contributing Employer will be notified in writing by the Administrator.

3. A Contributing Employer who makes contributions on behalf of any Non-Bargaining Employees must contribute on behalf of all full-time Non-Bargaining Employees. A full-time employee is one who works at least thirty (30) hours per week for the Contributing Employer.

b. Employee Application for Participation. Each Non-Bargaining Employee must make a written request to enroll on an approved form within thirty (30) days of becoming eligible to do so. Forms are available from the Administrator. The Non-Bargaining Employee application form must include the following information for each Non-Bargaining Employee:

1. name of Non-Bargaining Employee and each Dependent;

2. Non-Bargaining Employee's Social Security Number;

3. marital status of the Non-Bargaining Employee;

4. date of birth of the Non-Bargaining Employee and each Dependent;

5. sex of the Non-Bargaining Employee and the relationship of each Dependent; and

6. date of employment.

c. Classes of Employees Eligible. Non-Bargaining Employees include:

1. Non-Bargaining Employees of a sole proprietorship (not including the owner);

2. Non-Bargaining Employees of a partnership (not including the partners);

3. Non-Bargaining Employees of corporations;

4. Non-Bargaining Employees of local Unions; and

5. Non-Bargaining Employees of the SMCNA Colorado.

Self-employed persons are not eligible for coverage provided by the Fund and contributions cannot be accepted from self-employed persons, owners or partners.

d. Employer Participation Effective Date. The effective date of the Contributing Employer's non-bargaining participation shall be the first day of the calendar month following the date of notification from the Administrator that the application has been approved by the Board of Trustees.

e. Employee Effective Date of Coverage. All full-time Non-Bargaining Employees and their Dependents, will become eligible for coverage on the initial effective date of the Contributing Employer's participation. Newly hired Non-Bargaining Employees will become eligible for coverage on the first day of the calendar month next following or coinciding with thirty (30) days of full-time employment.

f. Monthly Premium Payment. The amount of the monthly premium to be remitted by the Contributing Employer on each participating Non-Bargaining Employee will be established by the Board of Trustees. The Contributing Employer will initially pay an amount equal to two (2) months' premium. Thereafter, monthly contributions are due in advance of the first day of the month for which coverage is intended.

g. Benefits. Non-Bargaining Participants shall be entitled to all benefits, except Accident and Sickness Weekly Benefits.

h. Termination of Coverage. Coverage will terminate on the earliest of the following dates:

1. if a Non-Bargaining Employee's employment terminates, coverage will terminate at the end of the month during which such termination occurs.

2. the last day of the month the Contributing Employer does not remit the required premium payment for any Non-Bargaining Employee within the specified time.

3. the date the Plan is discontinued.

4. the last day of the month following the month of the Non-Bargaining Employee's death.

5. in the event a Contributing Employer is delinquent in remitting contributions or submitting monthly reports for bargaining and/or Non-Bargaining Employees, coverage will terminate for Non-Bargaining Employees on the first (1st) day of the month for which the Contributing Employer is delinquent.

i. Family and Medical Leave Act (FMLA). Non-Bargaining Employees shall be entitled to benefits under the Plan during a family or medical leave in accordance with the provisions of the Family and Medical Leave Act of 1993, as may be amended.

Contributing Employers will be required to pay on the basis of eight (8) hours per day, up to a maximum of forty (40) hours per week while an Non-Bargaining Employee is on an approved absence under the terms of the Family and Medical Leave Act of 1993.

2.03 Eligibility for Dependents.

a. Effective Date. The effective date with respect to any Dependent's eligibility shall be determined as follows:

1. if an Eligible Employee has any Dependents on the date he/she becomes eligible for coverage under the Eligibility Rules, the Dependents shall become eligible on the same date.

2. if an Eligible Employee acquires a Dependent after the date upon which he/she becomes eligible, the Dependent spouse shall become eligible on the date of marriage. A Dependent child shall become eligible on the date born or upon which he/she becomes a Dependent as defined in section 1.14.

b. Termination of Dependent Benefits. A Dependent's eligibility shall automatically terminate upon the occurrence of the first of the following events:

1. when the Dependent ceases to be a Dependent as set forth under definition of Dependent, section 1.14.

2. when the Eligible Employee's own eligibility terminates, except that in the event of an Active Employee's death, eligibility for Dependents will be extended to the normal termination date, based upon the Active Employee's eligibility record, as outlined under section 2.01, e., Termination of Eligibility. Thereafter any rights would exist under section 2.04.

3. A Dependent of a Retired Employee who is Medicare-eligible and enrolls in the Medicare Part D prescription drug plan, during any period in which the Plan receives the Retiree Drug Subsidy, such Dependent shall not be entitled to continue coverage under the Plan as set forth in section 2.04, d. and shall not be allowed to reinstate coverage under this Plan at a future date.

2.04 Self-Payment Provisions for Continuation Coverage.

a. COBRA. Eligible Employees and Dependents who are Qualified Beneficiaries may have rights to continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") as provided below.

1. Eligibility. A Qualified Beneficiary may continue coverage under this section 2.04 for the maximum periods specified below, by making election to do so with the Administrator and submitting the applicable self-payment contribution.

A Qualified Beneficiary who may be entitled to a SASMI continued benefit must still elect COBRA during the sixty (60) day election period described below. If such Qualified Beneficiary is later approved for SASMI continued benefits, SASMI contributions will be applied to the COBRA premium payment and Participants will be responsible for any premium difference between self-pay contributions required under the COBRA provisions and the SASMI contributions. If SASMI continued benefits terminate prior to the exhaustion of the COBRA continuation coverage under this Plan, a Qualified Beneficiary must remit payment within thirty (30) days of the notification of SASMI benefit termination for premiums for all months after the SASMI continued benefits terminate.

If a Qualified Beneficiary who is an Eligible Employee or the spouse of an Eligible Employee elects Continuation Coverage and does not specify that the election is for self-only coverage, the election will be deemed to include an election of Continuation Coverage on behalf of all other Qualified Beneficiaries with respect to that Qualifying Event. However, each Qualified Beneficiary with respect to any Qualifying Event may elect coverage or waiver on an individual basis by providing the Administrator with the appropriate notice as set forth below. Notice on behalf of a minor child may be provided by the child's parent or legal guardian.

2. Maximum Self-Payment Period.

(a) Qualifying Event Affecting Employment. A Qualified Beneficiary may elect eighteen (18) months of Continuation Coverage from a Qualifying Event affecting employment (i.e., termination of employment or reduction in hours). An Eligible Employee who self-pays under this section may have additional self-payment rights under section 2.04, d. below.

In addition, if a Qualified Beneficiary has a child born, or if a child is placed for adoption during a period of COBRA coverage, the Qualified Beneficiary may elect COBRA continuation coverage for that child for the remainder of the COBRA coverage period provided the child is enrolled in accordance with the Plan's rules.

Coverage for the newborn or adopted child will continue for the same time as coverage for Dependent children who were properly enrolled in the Plan on the day before the Qualifying Event. Newborn or adopted children added to COBRA coverage also become Qualified Beneficiaries.

(b) Qualifying Event Due to Death of an Eligible Employee, Legal Separation or Divorce, or the Termination of Dependent Status for a Formerly Dependent Child. A Qualified Beneficiary who was a Dependent of an Eligible Employee may elect up to thirty-six (36) months of Continuation Coverage from the date of a Qualifying Event due to death of an Eligible Employee, legal separation or divorce, or the termination of dependent status for a formerly Dependent child.

Coverage may be continued for an eligible Dependent who is properly enrolled on the day before the event resulting in loss of eligibility (listed above). Each eligible Dependent has the independent right to elect or reject COBRA continuation coverage. The Participant may elect coverage on behalf of his/her spouse and family members. An election on behalf of a Dependent child can be made by the child's parent or legal guardian.

If one of the Qualifying Events listed above occurs and an Eligible Employee and/or Dependents lose coverage under the Plan and the Eligible Employee and/or Dependents do not elect COBRA coverage or, if applicable, do not elect to continue coverage at a higher premium, the Eligible Employee and/or Dependent's health coverage under the Plan will end.

(c) Disability During a Period of Continuation Coverage. If a Qualified Beneficiary is found to be entitled to Medicare due to disability (as determined by the Social Security Administration) at any time during the first sixty (60) days of Continuation Coverage, the eighteen (18) month coverage period may be extended up to eleven (11) additional months, to a total maximum of twenty-nine (29) months from the date of the Qualifying Event, for the disabled individual and family members who have also elected Continuation Coverage based on the same Qualifying Event. In order to elect the additional coverage, the Administrator must be informed by a Qualified Beneficiary affected by the Qualifying Event of the disability determination of the Social Security Administration no later than a date that is both within sixty (60) days of the date the determination is issued and before the end of the original eighteen (18) month maximum coverage period that applies to the Qualifying Event.

(d) Disability Prior to a Qualifying Event Affecting Employment. If an Eligible Employee experiences a Qualifying Event affecting employment less than eighteen (18) months after the date upon which said Eligible Employee has been found to be entitled to Medicare due to disability (as determined by the Social Security Administration), the period of coverage for Qualified Beneficiaries other than the Eligible Employee may be extended to thirty-six (36) months from the date upon which the Eligible Employee had been determined to be entitled to Medicare due to disability.

(e) Multiple Qualifying Events. If a Qualifying Event other than one affecting employment occurs during the eighteen (18) months after the date of a Qualifying Event affecting employment, the coverage period may be extended up to eighteen (18) additional months, up to a maximum of thirty-six (36) months from the date of the initial Qualifying Event.

(f) Retiree's Rights. An employer's filing a proceeding in bankruptcy under Title 11 of the United State Code may be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to the employer for whom a retiree worked while covered as an Eligible Employee under the Plan and that bankruptcy results in the loss of retiree health coverage under the Plan, the retiree will become a Qualified Beneficiary with respect to the bankruptcy. The retiree's spouse, surviving spouse, and Dependent children will also become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

3. Procedures to Elect COBRA Continuation Coverage. All notifications under COBRA must comply with these provisions. Notice should be mailed or hand delivered to the Plan at:

Colorado Sheet Metal Workers' Local 9 Family Health Plan
Attn: Mary Martin
Mailing address: PO Box 27910, Denver, CO 80227-0910
Street address: 7510 West Mississippi, Suite 200
Lakewood, Colorado 80226

The written notice of a Qualifying Event must include the following information: name and address of affected Participant and/or beneficiary, Participant's Social Security number, date of occurrence of the Qualifying Event, and the nature of the Qualifying Event. In addition, you must enclose evidence of the occurrence of the Qualifying Event (for example: a copy of: divorce decree, separation agreement, death certificate, Dependent's birth certificate). Once the Plan receives timely notification that a Qualifying Event has occurred, COBRA coverage will be offered to the Participant and Dependents, as applicable.

It is crucial that Participants and beneficiaries keep the Plan informed of their current addresses. Immediately inform the Plan, at the above address, in the event of a change of address of any Participant.

(a) Employer Notices and Plan Administrator Procedures. The Contributing Employer of a Non-Bargaining Employee must notify the Plan, in writing, within thirty (30) days of the following Qualifying Events with respect to the Non-Bargaining Employee: the Non-Bargaining Employee's death, termination of the Non-Bargaining Employee's employment, reduction in working hours, the Non-Bargaining Employee's entitlement to Medicare, or the Contributing Employer's initiation of bankruptcy proceedings.

The Contributing Employer's failure to provide timely notice of a Qualifying Event with respect to a Non-Bargaining Employee may subject the Contributing Employer to federal excise taxes. Furthermore, if a Contributing Employer does not give written notice within thirty (30) days of the Qualifying Event with respect to a Non-Bargaining Employee, and as a result, the Plan pays a claim for a person whose coverage terminated due to such Qualifying Event, that Contributing Employer must reimburse the Plan for any claims that should not have been paid.

With respect to Active Employees, the Administrator will determine, based on information obtained from a Contributing Employer's

remittance reports or other information, the occurrence of a Qualifying Event due to the Active Employee's death, termination of employment, reduction in working hours, entitlement to Medicare or the employer's initiation of bankruptcy proceedings.

(b) Eligible Employee and Dependent Notices. The Eligible Employee or Eligible Dependent must inform the Plan, in writing, within sixty (60) days of the following Qualifying Events in order to maintain the right to COBRA Coverage: divorce or legal separation of an Eligible Employee, a Dependent child's loss of Dependent status as defined by the Plan, or disability determination of the Social Security Administration. Both the Eligible Employee and the affected Dependent are jointly responsible for this notice.

In addition, the Eligible Employee or Eligible Dependent must notify the Plan immediately if he or she becomes covered by any other plan of group health benefits, whether through the Eligible Employee's or Dependent's employment or spouse's employment or otherwise.

If the Eligible Employee or Eligible Dependent(s) fails to give written notice to the Plan of a Qualifying Event within the required sixty (60) days, the affected person will lose the right to COBRA Coverage. If the Eligible Employee or Eligible Dependent(s) does not give written notice within sixty (60) days of the date of the Qualifying Event, and as a result, the Plan pays a claim for a person whose coverage terminated due to a Qualifying Event, the Eligible Employee or Eligible Dependent(s) must reimburse the Plan for any claims that should not have been paid. If the Eligible Employee or Eligible Dependent(s) fails to reimburse the Plan, then all amounts due may be deducted from other benefits payable on behalf of that individual or on behalf of the Eligible Employee, or Dependent.

(c) Plan's Notice of COBRA Rights. Within fourteen (14) days of receiving notice of any of the above Qualifying Events, or the Administrator's determination of a Qualifying Event, the Plan will notify the Eligible Employee or Eligible Dependent of the right to continue coverage and the applicable rates.

(d) COBRA Election Period. After notification of the availability and rates regarding Continuation Coverage, the Qualified Beneficiary will have sixty (60) days to elect Continuation Coverage on the required forms after the later of:

(i) the date that the Qualified Beneficiary would lose coverage on account of the Qualifying Event; or

(ii) the date that the Qualified Beneficiary is sent such notice.

Notification under this section is assumed to have been given on the date it is sent to the Administrator.

(e) Coverage During the Election Period. If a Qualified Beneficiary makes a timely election of Continuation Coverage, along with timely payment, coverage will be extended retroactively to the date upon which coverage would otherwise have been lost, but no claims will be

paid during the election period prior to an effective election being made.

(f) Waiver of Continuation Coverage. Continuation Coverage may be waived either by failing to make a timely election to receive coverage or by notice of waiver sent to the Administrator. A notice of waiver will be effective on the date the notice is sent to the Administrator.

A Qualified Beneficiary who waives Continuation Coverage during the election period can revoke the waiver at any time before the end of the election period, but in such instance, coverage will extend back only to the date on which the revocation is sent to the Administrator.

4. Payment of COBRA Continuation Coverage Premiums. The cost to continue benefits is 102% of the cost of coverage, as determined annually by the Plan. The cost will be specified in the notice of right to elect continuation of coverage sent by the Plan. However, the COBRA premium for the eleven (11) month disability extension period (if applicable) is increased to 150% of the cost of coverage. If your former participating employer alters the level of benefits provided through the plan to similarly situated active employees, your coverage and cost also will change.

The Trustees will determine the premium for the continued coverage. The premium will not necessarily be the same as the amount of the monthly contribution that a participating employer makes on behalf of a covered employee. The premium will be fixed, in advance, for a twelve (12) month period. The COBRA premium will be changed at the same time every year for all COBRA beneficiaries, therefore, the premium may change every year for an individual beneficiary before he/she has received twelve (12) months of COBRA coverage.

You will not be billed; it is your responsibility to remit payments to the Plan. Late payments will result in termination of coverage.

(a) First Monthly Payment. The first monthly payment, which will include premiums for all months since coverage terminated, must be received by the Administrator within forty-five (45) days of the date on which the Qualified Beneficiary elects to continue coverage, i.e., the date upon which the election to continue coverage was sent to the Administrator.

(b) Subsequent Monthly Payments. After the first payment, each additional monthly payment is due by the first day of the month for which coverage is intended, and shall be considered timely if received within thirty (30) days of the date due.

If SASMI continued benefits terminate prior to the exhaustion of the COBRA Coverage period, the Qualified Beneficiary must remit payment which will include premiums for all months since SASMI continued benefits terminated, within thirty (30) days of the date that the Qualified Beneficiary is notified of SASMI termination.

(c) Termination for Untimely Payment. If premiums are not received in a timely manner, coverage will terminate and cannot be reinstated. No

claims will be paid until premium payment is received by the Administrator in accordance with section 2.04, d., 1. and 2.

In the event insufficient funds are submitted, the Administrator shall notify the Qualified Beneficiary of the insufficiency, and the deficient premium must be received by the Administrator within thirty (30) days of such notice, or coverage will automatically terminate for the period of coverage for which the insufficient payment was made.

5. Termination of COBRA Continuation Coverage. COBRA Coverage will terminate on the earliest of the following dates, as applicable:

(a) Alternative Coverage. The date, after election of Continuation Coverage hereunder, upon which the Qualified Beneficiary first becomes covered under any other group medical coverage as an employee or dependent. In the event such other group medical coverage has a pre-existing condition clause or limitation, Continuation Coverage will not terminate until exhaustion of the maximum period for Continuation Coverage or until the pre-existing condition clause or limitation has been satisfied, whichever comes first.

(b) Cessation of Payment. The last day of the period for which the last payment was made for coverage in a timely manner.

(c) Exhaustion of Maximum Coverage. The date that the maximum continuation period has been exhausted.

(d) Medicare Coverage. The first date after the election of Continuation Coverage upon which the Qualified Beneficiary is found to be entitled to Medicare, except as set forth herein.

(e) Discontinuance of the Plan. The date the Plan is discontinued.

(f) Exhaustion of Lifetime Maximums. The date on which the lifetime benefit maximum is exhausted on all benefits.

(g) No Longer Disabled. The first month that begins more than thirty (30) days after the date of the Social Security Administration's determination that you or your eligible dependent is no longer disabled, in situations where coverage was being extended for eleven (11) months, provided the period of continuation coverage does not exceed twenty-nine (29) months.

6. Employer Withdrawal from Fund. If an Active Employee becomes ineligible for coverage under section 2.01, e., 2. because the employer has withdrawn from the Fund, such withdrawal is not a Qualifying Event and neither such employee nor his Dependents shall be eligible for COBRA Continuation Coverage under this section 2.04.

7. Trade Act of 2002. The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation ("PBGC") (eligible individuals). Under these tax provisions, eligible individuals can either take a tax credit or get

advance payment of 65% of premiums paid for qualified health insurance, including COBRA continuation coverage. If you have questions about the tax provisions, you may call Health Coverage Tax Credit Customer Contact Center toll-free 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/2002act_index.asp. This program is offered by the federal government and the Plan has no role in its administration.

b. Benefits. Continuation coverage under this section 2.04 shall include all benefits under the Plan for which the Employee was eligible immediately prior to termination of coverage.

c. Continuation of Coverage During Military Leave (USERRA).

1. Eligibility. An Eligible Employee who enters service with the Uniformed Services, as defined by the Uniformed Services Employment and Reemployment Rights Act (USERRA), may continue coverage under the Plan during that leave period in accordance with the following provisions. USERRA applies to Employees who are absent from employment due to military service, including Reserve and National Guard Duty under federal authority. The right to elect USERRA coverage does not apply to Dependents who enter military service. USERRA rights do not apply to service in a state national guard under authority of the state law. In addition to the right to continued coverage under USERRA, Employees (or Dependents) also may have rights to elect continuation coverage under COBRA, above. The period of continuation coverage under COBRA and USERRA will run concurrently, i.e., COBRA coverage is not available after USERRA coverage terminates and vice versa. In the event of a conflict between this Plan and the provisions of USERRA, the provisions of USERRA will control.

2. Period of Coverage. An Employee that qualifies for USERRA coverage is entitled to continue coverage for up to twenty-four (24) months, including coverage for Dependents. The period of coverage begins on the first day of the month after the Employee's absence for military service begins.

3. Notice and Election of USERRA Coverage. The Employee must notify his or her employer or the Administrator of the absence from employment due to military service, unless giving notice is precluded by military necessity or unless, under all the relevant circumstances, notice is impossible or unreasonable. If the Participant wishes to elect USERRA coverage, he or she also must notify the Administrator within sixty (60) days of the last day of employment unless the Participant is excused from giving advance notice of service under the provisions of USERRA. While an Employee may notify an employer of service orally, the Administrator requires that Participants elect USERRA coverage in writing. The Administrator will provide the necessary forms.

4. Premiums. The Employee may be required to pay all or a portion of the cost of the USERRA benefits.

(a) If the period of military service is less than thirty-one (31) days, there is no charge for this coverage to the Employee beyond the normal Deductible or copayments that would be paid if the Employee were employed. The Employer of an Active Employee shall not be responsible for contributions for an Active Employee during this 30-day period; however, the Employer of a Non-Bargaining Employee

shall be responsible for the applicable contribution for a Non-Bargaining Employee during this 30-day period.

(b) If the military service extends more than thirty-one (31) days, the Participant must pay 102% of the cost of the coverage. The cost will be determined in the same manner as the costs for COBRA continuation coverage.

The first monthly payment, which will include premiums for all months since coverage terminated, must be received by the Administrator within forty-five (45) days of the date on which continuation of coverage was elected.

Thereafter each additional monthly payment is due by the first day of the month for which coverage is intended, and shall be considered timely if received within thirty (30) days of the date due. If payment is not received by the end of this grace period, USERRA coverage will terminate as of the end of the last period for which payment was received. If the Participant fails to pay the full payment by each due date (or within the 30-day grace period), the Participant will lose all USERRA coverage and such continuation coverage cannot be reinstated.

Once a timely election of USERRA coverage has been made, it is the responsibility of the Participant to make timely payment of all required payments. The Fund will not send notice that a payment is due or that it is late, or that USERRA coverage is about to be terminated due to the untimely payment of a required payment.

5. Return to Covered Employment. If a former employee is discharged within five (5) years (unless extended service is required as part of the initial period of obligation or the service is involuntarily extended, such as during a war), his/her full eligibility will be reinstated in the Plan on the day he/she returns to work with a Contributing Employer, provided such former employee notifies a contributing Employer of the intent to return to Covered Employment within:

(a) ninety (90) days from the date of discharge if the period of service was more than one hundred eighty (180) days; or

(b) fourteen (14) days from the date of discharge if the period of service was thirty-one (31) days or more but less than one hundred eighty - one (181) days.

For USERRA to apply, the former Employee must receive an honorable discharge or satisfactorily complete military service. If the former employee is hospitalized for or convalescing from any illness or injury caused by active duty, the time limits to submit the application for reemployment are extended to the end of the period necessary to recover and in no case beyond two (2) years.

If the Employee met the Plan's eligibility requirements at the time he or she entered the Uniformed Services, the Employee will not be subject to any additional exclusions or a waiting period for coverage under the Fund upon return from to Covered Employment, unless an Active Employee elects to use his hour bank, in lieu of payment for part or all of USERRA coverage, as described below.

6. Hour Bank. An Active Employee who has sufficient hours to maintain eligibility under section 2.01, e. (Hour Bank) after military service commences has the option to:

(a) use the Hour Bank to continue coverage in lieu of paying for all or part of USERRA coverage; or

(b) pay for USERRA coverage commencing with the first day of the month after military service commences and maintain the Hour Bank balance to re-establish eligibility upon his or her return to Covered Employment.

If the Active Employee uses the Hour Bank and the Hour Bank is depleted during the period of service, he or she may pay for USERRA coverage for the balance of the USERRA period. For example, if an Active Employee has six (6) months of Hour Bank eligibility, he could decide to use the six (6) months of Hour Bank eligibility and pay for eighteen (18) months of coverage, for a total of twenty-four (24) months of USERRA coverage. Upon reemployment, the Employee may pay for coverage until he or she earns the hours necessary to again become eligible for ongoing coverage under section 2.01, e. Alternatively, an Active Employee may maintain his or her Hour Bank balance and pay for USERRA coverage for up to twenty-four (24) months, so that he will have the Hour Bank balance available upon reemployment.

Participants must advise the Fund whether they wish to use their Hour Bank within the time limits described above for electing and paying for USERRA coverage.

If the individual does not return to work for a Contributing Employer within the time frames above, all hours remaining will be forfeited to the Plan. If the individual subsequently enters Covered Employment, he or she would be treated as a new employee.

7. Termination of USERRA Coverage. Continuation of coverage under USERRA will terminate on the earliest of the following dates, as applicable:

(a) the end of the period for which the last payment was made for coverage in a timely manner;

(b) an individual returns to work and becomes covered under this Plan; or

(c) the end of the twenty-four (24) month period, beginning on the first day of the month after the absence begins; or

(d) the day after the date on which the participant is required but fails to apply under USERRA for return to a position of Covered Employment. However, the coverage under this Plan may continue even if the individual on military leave becomes covered under another group health plan sponsored by the Uniformed Services of the Department of Defense.

d. Extension of Continuation Coverage. Certain classes of employees are eligible to continue self-payment coverage under the Plan beyond the periods of coverage set forth above, as follows:

1. Retired Employees. An Active Employee who retires and is awarded a pension from the Sheet Metal Workers' Local 9 Pension Fund or the Sheet Metal Workers' National Pension Fund may continue coverage under the terms and conditions of this section for him/herself and his/her Dependents by self-paying the applicable retiree premium (which may be modified from time to time by the Trustees) as long as he/she is receiving a monthly pension, provided this Plan offers retiree coverage, which may be modified or terminated at any time by the Trustees. In the event a Retiree suspends his/her retirement and returns to Covered Employment his/her eligibility may be reinstated as set forth in section 2.01,f.

   Retired Employees (or Dependents of Retired Employees) who are Medicare-eligible and who enroll in a Medicare Part D prescription drug plan, during any period for which the Plan receives the Retiree Drug Subsidy, shall not be entitled to continue coverage under this Plan for any benefits (medical as well as prescription drug) and will not be allowed to reinstate coverage under this Plan at a future date.

2. Disabled Employees. An Eligible Employee who has incurred a Qualifying Event may continue coverage for him/herself and his/her Dependents under the terms and conditions of this section for as long as he/she provides proof to the Board of Trustees, when requested, that he/she:

   (a) remains disabled and is enrolled in a Approved Rehabilitation Program; or

   (b) has been awarded a total disability benefit through the Social Security Administration.

   "Approved Rehabilitation Program" means:

   (a) a program of Vocational Rehabilitation, whether formal or informal as approved by the Board of Trustees, or

   (b) a period of part-time work for purpose of rehabilitation, as approved by the Board of Trustees, or

   (c) the period of time during which the disabled individual continues formal education as a student in an institution of higher learning, for example, a college, university or their equivalent, as approved by the Board of Trustees.

3. All Other Self-Pay Employees. All other Self-Pay Employees may continue coverage as follows:

   (a) A former Non-Bargaining Employee who was eligible for coverage for forty-eight (48) out of the last sixty (60) months from the same Contributing Employer at the time of loss of eligibility may continue to make self-payments indefinitely.

   (b) Until the last day of any month during which any other Self-Pay Employee's name fails to appear on the Sheet Metal Workers International Association Local 9 out-of-work list.

4. Surviving Spouse or Dependent Children of a Deceased Eligible Employee. A surviving spouse or Dependent children who are covered under the Plan at the time of the Eligible Employee's death may elect to continue coverage after that otherwise provided under this section 2.04 until the earliest of the following events:

(a) the date the surviving spouse remarries, which event shall also terminate coverage for Dependent children;

(b) the date the surviving spouse or Dependent child becomes eligible for other group coverage;

(c) the date the required premium is not paid timely;

(d) the failure by the surviving spouse to file with the Administrator annually, a statement under penalty of perjury, of the marital status of the surviving spouse;

(e) the date the Dependent child no longer qualifies as a Dependent or the date the surviving spouse's coverage terminates;

(f) the date of the death of the surviving spouse.

Such eligible Dependents are not required to be receiving a pension from the Sheet Metal Workers Local 9 Pension Fund or the Sheet Metal Workers National Pension Fund.

2.05 Special Enrollment. If an Eligible Employee declines coverage for himself or his/her Dependents (including a spouse) because of other health insurance or group health plan coverage, such employee may enroll himself and his/her Dependents in this Plan if the Employee or Dependents lose eligibility for that other coverage (or if the employer stops contributing towards such other coverage). The Eligible Employee may request enrollment at any time after the other coverage ends (or after the employer stops contributing towards such other coverage). In addition, if an Eligible Employee gains a new Dependent as a result of marriage, birth, adoption, or placement for adoption, the Eligible Employee may enroll the Dependent for coverage. However, the Employee must request enrollment within thirty (30) days after the marriage, birth, adoption or placement for adoption in order for coverage to be effective on the date of the marriage, birth, adoption or placement for adoption as provided in section 2.03, a. above; enrollment after the thirty (30) day period will result in coverage effective from the first of the month following enrollment.

To request special enrollment or obtain more information, contact the Administrator at 303-922-1213, extension 14 or 1-888-831-1213.

2.06 Creditable Coverage.

a. Certificate of Creditable Coverage. When coverage ends, Participants are entitled by law to, and will automatically be provided (free of charge) a Certificate of Coverage that indicates the period of time such Participants were covered under the Plan. The certificate will be provided within a reasonable time after the Plan knows or has reason to know that coverage has ended (or if the Participant is eligible for COBRA continuation coverage, within the time period for providing the COBRA notice).

b. Procedure for Requesting and Receiving a Certificate of Creditable Coverage. A Certificate of Creditable Coverage will be provided upon receipt of a written request

for such a certificate that is received by the Administrator within two (2) years after the date coverage ended under this Plan. The written request must be mailed to the Administrator and should include the name of the individuals for whom a certificate is requested (including spouse and dependent children) and the address where the certificate should be mailed. A copy of the certificate will be mailed by the Plan to the address indicated.

3. ACCIDENT AND SICKNESS WEEKLY BENEFITS

3.01 **Weekly Benefits.** If an Active Employee becomes Totally Disabled on or after July 20, 2006 as a result of accidental bodily injuries or sickness not arising out of or in the course of employment, the Plan will, upon a Physician's certification of Total Disability satisfactory to the Board of Trustees and subject to the provisions hereafter stated, pay to the employee during the period of such Total Disability, **$210 per week.** For each day during partial weeks of Total Disability the benefit will be one-seventh of the weekly benefit. Benefits commence on the first day of the Total Disability for an accident and the eighth day of Total Disability resulting from a sickness. Benefits are payable for a maximum period of **thirteen (13) weeks.**

A period of Total Disability begins on the first day Total Disability is certified by a Physician.

"Sickness" shall include pregnancy, childbirth or a related medical condition.

3.02 **Successive Periods of Disability.** Successive periods of disability separated by less than two (2) weeks of active work shall be considered one (1) period of disability unless the subsequent period of disability is due to injuries or sickness entirely unrelated to causes of the previous disability and commences after return to active work on a full-time basis.

3.03 **Exclusions and Limitations.** In addition to the General Exclusions and Limitations in Section 7, Accident and Sickness Weekly Benefits are not payable for the following:

a. any disability during which the employee is not under the care of a legally qualified Physician as defined in section 1.39 (Page 29).

b. during a period in which an employee is receiving remuneration for any work or service, unemployment benefits or loss of time from any other group insurance benefits.

c. when an employee is receiving benefits through the Sheet Metal Workers' Local 9 Pension Trust.

4. COMPREHENSIVE MEDICAL BENEFITS -- SCHEDULE A

4.01 **Maximum Benefits Payable.** If a Participant receives treatment for a bodily injury or sickness, the Plan will, subject to the provisions of the Plan and after the satisfaction of any required Deductible (described in section 4.02) pay for each Participant the percentage of Covered Charges (described in section 4.03), not to exceed the maximum benefits payable described below. All benefits paid on behalf of a Participant are combined and applied toward the aggregate lifetime maximum amount described herein.

a. Aggregate Lifetime Maximum Amount. The aggregate lifetime maximum amount payable on behalf of any Participant for all Covered Charges shall not exceed **$1,000,000**, including Prescription Drug Benefits. In addition, certain covered charges have specific lifetime maximums, described in subsection b. below.

In no event shall an increase in the lifetime maximum benefit apply to any Participant who has exhausted his/her lifetime maximum benefit prior to the Restatement Effective Date or prior to the effective date of an increase in the lifetime maximum benefit. In addition, when determining the lifetime maximum benefit, all claims paid by the Plan, including any of the Plan options (Schedule A and/or Schedule B), over the Participant's lifetime participation shall be aggregated and be applied to the applicable lifetime maximum benefit. All benefits paid on account of expenses incurred prior to the Restatement Effective Date shall be counted towards satisfying the aggregate lifetime maximum benefit. The description of the maximum as a "Lifetime" maximum does not mean, nor should it be construed to mean, that the Plan has any obligation to pay any benefits during the lifetime of the Plan Participant after coverage terminates.

b. Specific Lifetime Maximums. In addition to the Aggregate Lifetime Maximum noted above, certain services are subject to a "specific" lesser lifetime maximum. The lifetime maximum amount payable on behalf of any Participant for all Covered Charges due to the following are:

1. **eight (8) days** of inpatient Respite Care.

2. **forty (40) inpatient days** or day equivalents for mental or nervous disorders and substance abuse, as described in section 4.05, d.

3. **$600** for Physician prescribed smoking cessation aids and smoking cessation programs as described in section 5.04, i.

In no event shall an increase in any lifetime maximum benefit apply to any Participant who has exhausted his/her lifetime maximum benefit prior to the Restatement Effective Date or prior to the effective date of an increase in the lifetime maximum benefit. In addition, when determining the lifetime maximum benefit, all claims paid by the Plan over the Participant's lifetime participation shall be aggregated and be applied to the applicable lifetime maximum benefit.

With respect to mental or nervous disorders and substance abuse, the Board of Trustees or their designated agent will determine the remaining inpatient days or day equivalents (described in section 4.05, d.) for any amount of the previous lifetime maximum which has been exhausted by a Participant.

c. Calendar Year Maximums. The maximum benefit payable on behalf of any Participant for all Covered Charges (other than Organ and Tissue Transplant Covered Charges) incurred during a calendar year shall not exceed **$250,000.** However, benefits payable during a calendar year shall be limited to the following specific maximums:

1. **$1,000** for speech and audio therapy (refer to section 4.05, p., 7. (Page 64) for a complete benefit description).

2. **thirty (30) visits** for chiropractic care (refer to section 4.05, q. (Page 64) for a complete benefit description).

3. **one hundred (100) days**, not to exceed $5,000, for home health services (refer to section 4.05, n., 2. (Page 63) for a complete benefit description).

4. **one hundred twenty (120) days** per calendar year for Skilled Nursing Facility (refer to section 4.05, e. (Page 60) for a complete description of benefits).

5. Routine Physical Benefits for:

   - the employee and spouse, up to **$400** per person per calendar year, and
   - the Dependent child, age five (5) and older, up to **$150** per person per calendar year.

   (Refer to section 4.05, m. (Page 62) for a complete description of benefits).

d. Surcharges. Some states, for example, New York, impose a surcharge (an additional amount added to the usual charge) to expenses for services provided by certain facilities (in New York, any of the following facilities located in New York state: Hospitals, both inpatient and outpatient (including emergency room), diagnostic and treatment centers, and ambulatory surgical centers). This surcharge changes from year to year. It is the responsibility of the Plan to pay the surcharge on any portion of the charges that are paid for by the Plan (after all applicable Copays and Deductibles). This surcharge will be considered a paid claim and will count toward each individual's maximum annual and maximum lifetime benefit. The surcharge will be considered a paid claim for subrogation and overpayment purposes under the Plan as well. No surcharge amounts will be paid by the Plan once an individual has reached the annual or lifetime maximum. It is the Participant's and/or the Dependent(s)'s responsibility to pay the surcharge to the provider on any amounts that are not paid for by the Plan. In addition to the expense surcharge, there is a monthly surcharge that the Plan must pay directly to the State of New York for each Participant and/or Dependent(s) residing there. This surcharge varies based on individual or family coverage and the geographic region in which the Participant and/or Dependent(s) live. This monthly surcharge will be counted toward each Participant's and/or Dependent(s)'s annual and lifetime maximum.

4.02 Deductible. The Deductible is the amount of Covered Charges incurred each calendar year before benefits are payable. Any amounts billed above the Covered Charge for a service will not be applied to satisfy the Deductible. The Deductible consists of **$500** of Covered Charges per Participant ($1,500 per family) each calendar year. Copayments do not accumulate to meet the Deductible.

There is no Deductible for PPO Physician office visit charges. The Deductible does not apply to the routine and preventive care benefits rendered by a PPO Physician described in section 4.05, m., or emergency room PPO Physician charges. In addition, the Deductible will be waived for after-hours care when:

a. services are rendered in the PPO network area;

b. no other PPO after-hours or walk-in clinics are available in that area; or

c. services provided at the PPO facility are charged as urgent or after-hours and not as an emergency room visit.

When two (2) or more Participants in the same family incur an aggregate of $500 in Covered Charges as the result of a common accident, $500 will meet the Deductible requirement for each Participant involved for the calendar year in which the accident occurred.

4.03 **Copayments and Percentage of Covered Charges Payable by the Plan.** Benefits are subject to the maximums described in section 4.01 and subject to the Deductible described in section 4.02. Participants are responsible for the applicable Copayment indicated in the Summary of Benefits (refer to Pages 3-9) and the percentage not paid by the Plan. Once the calendar year out-of-pocket maximum (excluding Deductible and Copayments) is met, as described in section 4.04, benefits are paid by the Plan at **90% or 100%** for the remainder of the calendar year.

The percentage payable for Covered Charges will be as follows:

a. PPO Covered Charges (In-Network).

1. PPO Physician. After satisfaction of a **$25*** office visit Copayment, Physicians services and short term rehabilitative therapy Covered Charges are paid at **100%**, except surgery performed in a Physician's office (refer to number 2. below).

*The office visit Copayment is waived for Medicare-eligible Participants and preventive services.

2. PPO Hospital and Other Facility Covered Charges (In-Network). After satisfaction of the Deductible Covered Charges, including Physician's charges for surgery performed in the Physician's office, are payable at **80%** until the PPO out-of-pocket maximum described below has been met for each calendar year.

b. Non-PPO Covered Charges (Out-of-Network). After satisfaction of the Deductible, Covered Charges are payable at **60%** until the Non-PPO (Out-of-Network) out-of-pocket maximum described below has been met for each calendar year. Refer to subsection d. below for a description of ambulance, emergency and urgent care services.

c. Non-PPO in Non-PPO Area (Non-Network Area). After satisfaction of the Deductible Covered Charges are payable at **70%** until the Non-PPO in Non-PPO Area (Non-Network Area) out-of-pocket maximum described below has been met for each calendar year. Refer to subsection d. below for a description of ambulance, emergency and urgent care services.

d. Ambulance, Emergency and Urgent Care. After satisfaction of the Deductible, Covered Charges for a Medical Emergency, ambulance or urgent care will be reimbursed at **80%** based on Usual, Customary and Reasonable Charges as defined on Page 31. PPO Physician services in the Hospital emergency room are subject to a $25 Copayment, then 80%. The $25 Copayment will be waived if the patient is admitted to the Hospital within twenty-four (24) hours of the emergency room visit.

4.04 **Calendar Year Out-of-Pocket Maximums**. When out-of-pocket expenses during a calendar year have reached the following maximums, the Plan will pay benefits at **90% or 100%** for the remainder of the calendar year. The Deductible and Copayments do not apply to the out-of-pocket maximums. PPO and Non-PPO Covered Charges may be combined for purposes of satisfying the calendar year out-of-pocket maximum.

a. PPO Out-of-Pocket Maximum (In-Network). **$3,000** per Participant (**$6,000** aggregate per family) during any one (1) calendar year; Covered Charges paid at **100%** for the remainder of the calendar year.

b. Non-PPO in PPO Area Out-of-Pocket Maximum (Out-of-Network). **$6,000** per Participant (**$12,000** aggregate per family) during any one (1) calendar year; Covered Charges paid at **90%** for the remainder of calendar year.

For services unavailable through a PPO, benefits will be payable at 100%, once the out-of-pocket maximum is met.

c. Non-PPO in Non-PPO Area Out-of-Pocket Maximum (Non-Network Area). **$4,500** per Participant (**$9,000** aggregate per family) during any one (1) calendar year; Covered Charges paid at **100%** for the remainder of the calendar year.

The following expenses do not accumulate to meet the out-of-pocket maximum:

1. the Deductible and Copayments.

2. expenses for medical services or supplies that are not covered by the Plan.

3. charges in excess of the Usual, Customary and Reasonable Charge determined by the Plan.

4. charges in excess of the Plan's Aggregate or Specific Lifetime and Calendar Year maximums.

5. any additional amounts required due to failure to comply with the precertification review program of this Plan.

4.05 Covered Charges. Covered Charges are Usual, Customary and Reasonable Charges (UCR), as defined on Page 31, for Medically Necessary services and supplies for those items described below. A Covered Charge is incurred at the time the service is rendered or the item is provided for which a charge is made. Covered Charges will not be recognized under more than one (1) of the following benefits.

a. Hospital Benefits. Hospital Benefits (other than for treatment of mental or nervous disorders or substance abuse), include:

1. the Hospital's charge for its daily average semi-private room rate. Unless otherwise specified, Hospital room and board benefits are payable for three hundred sixty-five (365) days during any one (1) calendar year.

2. Hospital charges for routine well baby nursery care of a newborn child.

3. Hospital miscellaneous charges for:

(a) services and supplies provided during confinement as a registered inpatient, at a time when the Hospital room and board benefits are payable.

(b) confinement in an Intensive Care Unit or Coronary Care Unit.

(c) whole blood or blood plasma, if not replaced, and the cost of its administration.

b. Ambulance Benefits. Benefits are payable for professional ambulance service for transportation to the nearest facility equipped to perform the necessary services. Air ambulance service is payable only if the Participant's condition is one which cannot be

managed in the locale where the accidental injury or sickness occurs or due to the Participant's critical condition.

c. Outpatient Hospital Benefits. Benefits are payable for outpatient Hospital care for treatment of an accidental bodily injury, sickness, or surgery. Charges for medical services and supplies provided during outpatient surgery will be considered Covered Charges if the charges are made by a Licensed Ambulatory Surgical Facility.

d. Mental or Nervous Disorders and Substance Abuse Benefits. When referred by the MAP, benefits are payable for treatment of mental or nervous disorders and substance abuse for services rendered by a Hospital, Health Care Practitioner, Physician or a Licensed Treatment Center. Benefits are payable up to a lifetime equivalent of **forty (40) inpatient days** per Participant, whether treatment is rendered for mental or nervous disorders or substance abuse. The table below outlines the specific conversion of services to inpatient days:

Services Delivered		***Inpatient Day Equivalents***
1 Inpatient Day	=	1 Inpatient Day
2 Partial Hospital Days	=	1 Inpatient Day
7 Outpatient Visits	=	1 Inpatient Day
14 Psychotherapy Group Sessions	=	1 Inpatient Day
1 Intensive Outpatient Program (IOP) (alcohol or drug treatment)	=	5 Inpatient Days

Any intensive outpatient services required for psychological care (as opposed to a full intensive outpatient program for substance abuse) would be calculated using the "outpatient visits" category above. In cases of relapse consequent to a Participant's involvement in a substance abuse program, their involvement in additional treatment would come out of the "outpatient visits" category unless the nature of the relapse, for clinical reasons, warranted a more intense level of care (i.e., IOP or Residential Care).

The Board of Trustees or their designated agent will determine the remaining inpatient days or day equivalent for any amount of the previous lifetime maximum which has already been exhausted by a Participant.

e. Skilled Nursing Facility. Benefits are payable up to **one hundred twenty (120) days** per calendar year for services or supplies which are provided by a Skilled Nursing Facility providing such confinement is in lieu of inpatient hospitalization.

f. Rehabilitation Facility. Benefits are payable for charges incurred by a Participant for room and board and miscellaneous services and supplies as a result of confinement in a Rehabilitation Facility.

g. Maternity Benefits. Benefits are payable for a female Eligible Employee or Dependent spouse of an Eligible Employee, as a result of pregnancy, childbirth or a related medical condition. Physician's and midwives obstetrical services, including prenatal and post-natal care shall be payable in accordance with UCR.

Plan benefits shall be payable for a complication of pregnancy for any covered female. A complication of pregnancy is an added difficulty, complex state, disease or accident superimposed on a pregnancy without being specifically related, yet affecting or modifying the prognosis of the pregnancy, as determined by the Claims Administrator or its designee. Complications of pregnancy can include but are not limited to the following diagnoses: anemia, bleeding during pregnancy, cervical incompetence, ectopic or molar pregnancy, gestational diabetes, excessive vomiting,

miscarriage, placenta abruptio or previa, preeclampsia, or preterm labor. Complications of pregnancy does not include common symptoms/discomforts associated with pregnancy such as spotting, false labor, morning sickness, skin changes, backache, headache, leg cramps, indigestion, constipation/hemorrhoids, or the usual lab/ultrasound tests to monitor status and progression of the pregnancy.

Maternity benefits for services rendered by a midwife shall be payable up to **$600** per pregnancy.

Maternity benefits shall be payable for charges incurred at a licensed birthing center.

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

Accordingly the Plan will not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or to less than ninety-six (96) hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods. This Plan does not prohibit the discharge of the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) as applicable) provided the mother and the Physician (nurse midwife or Physician Assistant) are in agreement.

Call CIGNA for Pre-Admission Approval for maternity admissions when the Hospital stay lasts or is expected to last longer than forty-eight (48) hours for a vaginal delivery and ninety-six (96) hours for a C-section.

h. Surgery/Anesthesia Benefits. Benefits are payable for the following surgical and anesthesia services:

1. Professional surgical and anesthesia services will be payable when rendered by a Physician in the performance of a surgical procedure.

2. Professional surgical services rendered by an assistant surgeon who is an MD or DO in the performance of a surgical procedure will be payable not to exceed 20% of the operating surgeon's benefit. The Plan will pay a benefit equal to the fee charged, not to exceed 15% of the operating surgeon's benefit allowed for the services of a legally licensed and qualified Physician Assistant or nurse practitioner who is acting in the stead of an assistant surgeon as part of the surgical team.

i. Radiotherapy. Benefits are payable for Physician's charges for radiotherapy, including the use of X-ray, radium, cobalt and other radioactive substances.

j. Chemotherapy. Benefits are payable for therapeutic services and treatment of malignant diseases and other conditions.

k. Diagnostic X-ray/Radiology and Laboratory Benefits. Benefits are payable for radiology and laboratory examinations for diagnosis of a disease or due to an accident (including allergy testing, basal metabolism determination, audiograms and electro-cardiograms).

l. Medical Services. Benefits are payable for charges incurred for medical services (other than for treatment of mental or nervous disorders or substance abuse) rendered by a Physician or Health Care Practitioner, as appropriate, as follows:

1. daily Physician visits when confined in a Hospital as a registered inpatient if room and board benefits are payable for the hospitalization.

2. in-hospital newborn pediatric care.

3. office visits and consultations.

4. Physician's visits at a place other than a Hospital or Physician's office.

5. therapeutic injections, allergy injections and antigens including antigen preparation.

6. services of a licensed Physician Assistant or Nurse Practitioner who is under the direct supervision of a Physician for the performance of medical services, including the prescribing of a non-controlled substance when the Physician does not see the patient or become directly involved in the medical services being provided.

m. Preventive Care. Benefits are payable for routine care as follows.

1. Children from Birth through Age Four. Benefits are payable for routine well baby visits and immunizations for children under age five (5).

2. Adults and Children Age Five and Older. Benefits are also provided for state required immunizations for children ages five (5) through eighteen (18). Benefits are payable for routine physicals, up to the following calendar year maximum amounts:

Eligible Employee and spouse - **$400** per person

Dependent child, age five (5) and older - **$150** per person

This benefit includes, but is not limited to:

(a) Physician's charges for a complete history and physical examination;

(b) X-ray and laboratory charges for electrocardiograms, complete blood count, urinalysis, chest X-rays;

(c) Papanicolaou smear once per calendar year;

(d) Routine prostate examination and blood test (PSAs) for Participants over forty (40) once per calendar year; and

(e) A routine mammogram once each calendar year.

n. Home Health Care. When a Physician certifies in writing that home care is necessary in lieu of Hospital or Skilled Nursing Facility confinement and the Physician submits a written treatment plan, benefits will be provided in accordance with the following:

1. all expenses for medical services or supplies which would have been payable under the Plan if the Participant would have been confined in a Hospital or Skilled Nursing Facility.

2. all expenses up to **100 days**, not to exceed a maximum benefit payable of **$5,000** per calendar year, for services provided to a Participant in a private residence by a registered nurse, a licensed vocational nurse, a licensed practical nurse, a licensed physical or speech therapist. The maximum number of hours per day is limited to sixteen (16) hours. Multiple visits can occur in one day. A visit is defined as a period of two (2) hours or less (e.g., maximum of eight (8) visits per day).

Home Health Care Benefits will not be provided for the following services:

1. a masseur, physical culturist or physical education instructor.

2. any services, which are not necessary to prevent or postpone the Participant's hospitalization.

3. any services rendered to the Participant which could have been provided by any other properly trained person of the household without endangering the Participant's life or seriously impairing his/her condition.

o. Hospice Care. If a Physician certifies that a Participant is a Terminally Ill Patient, the Plan will pay for Covered Charges during any Hospice Benefit Period. Hospice Care Covered Charges include:

1. all expenses for medical services or supplies which would have been payable under the Plan if the Participant would have been confined in a Hospital.

2. all expenses for special meals and nutrition counseling and services provided to a Terminally Ill Patient in a private residence by a registered nurse, a licensed practical nurse, a licensed vocational nurse, a licensed physical or speech therapist.

3. Bereavement counseling by a licensed or certified social worker for medical social services.

4. all expenses for medical services and supplies when confined in a facility maintained by a Hospice Agency.

5. all expenses for medical services and supplies when confined in a facility for Hospice Care when such confinement is for Respite Care so as to relieve the person residing with and caring for the Terminally Ill Patient in his/her home, provided that such expenses shall only be covered for such purposes for up to **eight (8) days** per lifetime.

No benefits will be payable for services provided by volunteers or individuals who do not normally charge for their services or for services which could have been provided by a member of the Participant's household without endangering the Participant's life or seriously impairing his/her condition.

p. Drugs, Appliances, Occupational Therapy, Physical Therapy and Nursing Care. Benefits are payable for:

1. rental of a wheel chair, Hospital bed, and other similar Durable Medical Equipment. When determined by the Board of Trustees or their delegates that purchase of Durable Medical Equipment would be less expensive than the rental thereof, or such equipment is not available for the rental, such purchase may be authorized by the Board of Trustees or their designated agent.

2. artificial limbs, eyes and other prosthetic devices and orthopedic appliances. This includes fitting, adjusting and repairs, but functional replacement will be limited to once in a five (5) year period when due to a change in the individual's physical condition or if the equipment cannot be satisfactorily repaired.

3. casts, splints, braces and crutches, and surgical dressings.

4. oxygen and rental of oxygen equipment.

5. charges made for professional services of a registered nurse, licensed practical nurse, licensed vocational nurse for Occupational Therapy or Physical Therapy when prescribed or provided by a Physician or when performed by a properly accredited occupational therapist (OT), a certified occupational therapy assistant (COTA) or a physical therapist.

   Charges for Occupational Therapy or Physical Therapy services are payable up to **sixty (60) days** per calendar year when in the judgment of the Physician significant improvement can be obtained. Additional need for therapy must be certified by the attending Physician to be Medically Necessary. Benefits are not payable for Occupational Therapy or Physical Therapy services to maintain function at the level to which it has been restored, or when no further significant practical improvement can be expected. Physical Therapy or Occupational Therapy which is prescribed by a Physician in lieu of non-medical treatment (e.g., exercise) is not considered Medically Necessary and is not payable by the Plan.

6. drugs and medicines dispensed by an institution covered by the Plan while the Participant is confined as an inpatient or on an outpatient basis in such institution.

7. speech and audio therapy, including audio diagnostic testing when performed by a therapist certified by the American Speech and Hearing Association, up to **$1,000** per calendar year.

8. contact lenses when their function is to replace a human lens lost through intraocular surgery or ocular injury. Limitation will be to **one (1) pair** of contact lenses.

q. Chiropractic Care. Benefits are payable for chiropractic services up to **thirty (30) visits** per calendar year.

r. Reconstruction Following a Mastectomy. Under Federal law related to mastectomy benefits, the Plan is required to provide coverage for: (1) reconstruction of the breast on which a mastectomy was performed; (2) surgery on the other breast to produce a

symmetrical appearance, and (3) prostheses and physical complications of all stages of mastectomy, including lymphedemas. Such benefits are subject to the Plan's annual Deductibles and coinsurance provisions.

s. Transplant Services. Charges made for human organ and tissue transplant services which include solid organ and bone marrow/stem cell procedures, are subject to the following conditions and limitations:

1. Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and

2. costs for organ or bone marrow/stem cell procurement.

Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants:

1. allogeneic bone marrow/stem cell,

2. autologous bone marrow/stem cell,

3. cornea,

4. heart/lung,

5. kidney,

6. kidney/pancreas,

7. liver,

8. lung,

9. pancreas or intestinal which includes small bowel, liver or multivisceral.

All Transplant services, other than cornea, are payable at 100% when received at CIGNA LIFESOURCE Transplant Network® facility. Cornea transplants are not covered at CIGNA LIFESOURCE Transplant Network® facilities. Transplant services, including cornea, when received from Participating Provider facilities other than CIGNA LIFESOURCE Transplant Network® facilities are payable at the In-Network level. Transplant services received at any other facilities are covered at the non-PPO level of benefits.

Coverage for organ/tissue procurement cost are limited to costs directly related to the procurement of an organ/tissue, from a cadaver or a live donor. Organ/tissue procurement costs shall consist of surgery necessary for organ/tissue removal, organ/tissue transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Charges made for reasonable travel expenses incurred in connection with a pre-approved organ/tissue transplant are covered subject to the following conditions and limitations:

1. transplant travel benefits are not available for cornea transplants. Benefits for transportation, lodging and food are available only if you are the recipient of a pre-approved organ/tissue transplant from a designated CIGNA LIFESOURCE Transplant Network® facility.

   The term recipient is defined to include a person receiving authorized transplant related services during any of the following:

   (a) evaluation,

   (b) candidacy,

   (c) transplant event, or

   (d) post-transplant care.

2. travel expenses for the person receiving the transplant will include charges for: transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility);

3. lodging while at, or traveling to and from the transplant site; and

4. food while at, or traveling to and from the transplant site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver.

These benefits are only available when the Participant is the recipient of an organ/tissue transplant. No benefits are available when the Participant is a donor, unless the recipient is a Participant.

The following are specifically excluded travel expenses:

1. travel costs incurred due to travel within 60 miles of your home;

2. laundry bills;

3. telephone bills;

4. alcohol or tobacco products; and

5. charges for transportation that exceed coach class rates.

5. OUTPATIENT PRESCRIPTION DRUG BENEFITS

5.01 **Benefits.** A Participant will be entitled to receive outpatient prescription drug benefits as described herein, after satisfaction of any applicable Copayment as described below. Prescription drug benefits are not subject to the Comprehensive Medical Deductible or

coinsurance provisions. However, prescription drug benefits do accumulate to meet the Aggregate Lifetime Maximum Amount described in section 4.01, a. (Page 56).

This Plan will not coordinate with Medicare Part D coverage and will terminate all coverage under the Plan for any retired employee or Dependent of a retired employee who elects Medicare Part D coverage during any period for which the Plan receives the Retiree Drug Subsidy.

5.02 Prescription Card Retail Program.

a. Participating Pharmacies (PPO). Each Participant will be issued a prescription drug identification card which must be presented to the participating pharmacy with each prescription to be filled or refilled. The Participant must pay the pharmacist the Copayment described below. The Plan will pay the remaining Covered Charges directly to the Participating Pharmacy.

1.	Generic Drug Copayment:	**$ 5.00**
2.	Preferred Brand Name Drug Copayment:	**$10.00**
3.	Non-Preferred Brand Name Drug Copayment:	**$25.00**
4.	Specialty Drugs Copayment:	**$25.00**

If a Participant selects a brand name drug when a generic is available and the Physician does not indicate otherwise, the Participant will be required to pay the difference between the cost of the brand name and generic drug.

b. Dispensing Limitations. The quantity of covered drugs normally prescribed by a Physician, but not to exceed a **thirty (30) day** supply.

5.03 Mail Order Program. If the Participant utilizes the Mail Order Prescription Drug Program for maintenance medications, such Participant will be entitled to receive prescription drugs as described below. Maintenance medications are those taken on a regular or long-term basis, such as drugs to treat diabetes or high blood pressure.

a. Copayment. The Participant will be required to satisfy the following Copayment:

1.	Generic Drug Copayment:	**$10.00**
2.	Preferred Brand Name Drug Copayment:	**$20.00**
3.	Non-Preferred Brand Name Drug Copayment:	**$50.00**
4.	Specialty Drug Copayment:	**$50.00**

b. Dispensing Limitations. The quantity of covered drugs normally prescribed by a Physician but not to exceed a **ninety (90) day** supply.

5.04 Covered Charges. Covered Charges include:

a. Legend drugs (drugs that require a prescription by federal law).

b. Insulin.

c. Disposable needles/syringes.

d. Disposable blood glucose test strips and urine testing products (e.g., Chemstrips, Acutest tablets, Clinitest tablets, Diastix Strips, and Tes-Tape).

e. Lancets.

f. Compounded medication of which at least one (1) ingredient is a legend drug.

g. Any other drug (including immunosuppressive drugs) which, under applicable state law, may only be dispensed upon the written prescription of a Physician or other lawful prescriber.

h. oral contraceptive drugs/injections, contraceptive devices, and contraceptive implants.

i. Physician prescribed smoking cessation aids (nicotine patches, medications or gum) only when used in conjunction and concurrently with an organized smoking cessation class or program which is successfully completed. The smoking cessation program will also be a covered charge under the Plan. Benefits are subject to the **$600** lifetime maximum.

j. drugs for the treatment of morbid obesity in accordance with the Morbid obesity benefits described in Exhibit A on Page 85.

5.05 **Exclusions.** In addition to the General Exclusions and Limitations, Prescription Drug Benefits are not payable for:

a. drugs or medications procured or procurable without a Physician's written prescription (such as over-the-counter).

b. growth hormones.

c. immunization agents, biological sera, blood or blood plasma.

d. Minoxidil (Rogaine) for the treatment of alopecia.

e. non-legend drugs other than those listed above in section 5.04.

f. therapeutic devices, or appliances, including support garments and other non-medical substances, regardless of intended use, except those listed above in section 5.04.

g. drugs labeled: "Caution - limited by federal law to investigational use," or experimental drugs, even though a charge is made to the Participant.

h. any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one (1) year from the original order of a Physician.

i. prescription drugs which may be properly received without charge under local, state, or federal programs including Worker's Compensation.

j. infertility medications.

k. any prescriptions payable under section 4.05, p., 6. (Page 64).

l. Ritalin and other drugs (cylert, dexedrine, adderall, desoxyn) including the generic equivalents, for Participants age eighteen (18) or over.

6. VISION BENEFITS

6.01 **<u>Benefits</u>.** If a Participant receives vision care, the Plan will pay covered charges of an ophthalmologist, optometrist or dispensing optician, not to exceed **$75** per employee/family, per calendar year. The $75 maximum is an aggregate amount for all family members.

6.02 **<u>Availability of Services</u>.** Benefits for examinations and/or materials are available once every calendar year.

7. GENERAL EXCLUSIONS AND LIMITATIONS

7.01 **<u>General Exclusions and Limitations</u>. IF ANY SERVICES OR SUPPLIES ARE NOT SPECIFICALLY ADDRESSED IN THIS PLAN, WHETHER AS AN EXCLUSION OR COVERED CHARGE, IT IS NOT TO BE ASSUMED THAT SUCH SERVICES OR SUPPLIES ARE COVERED UNDER THIS PLAN. ONLY MEDICALLY NECESSARY SERVICES OR SUPPLIES ARE COVERED, UNLESS SPECIFICALLY STATED OTHERWISE.**

This Plan shall not provide benefits for any treatment, accommodations, services or supplies rendered for or in connection with any treatment directly or indirectly related to:

a. any medical benefits paid by, reimbursed by, or provided by or under the authority of any government or any governmental agency. Such benefit shall discharge the obligation of this Plan as though and to the extent such benefit had been paid hereunder; however, no claim will be denied solely because treatment or services are rendered in a Hospital owned or operated by a State or a political subdivision thereof. Benefits will be payable for services and supplies rendered in a Veteran's Administration Facility, unless such services or supplies are for a service-connected disability.

b. charges a Participant is not obligated to pay, is not billed or would not have been billed except for the fact that the person was covered under this Plan.

c. treatment, unless that treatment is Medically Necessary (**except** as otherwise specifically provided for herein) and is generally accepted medical practice and then only to the extent that the charge is within Usual, Customary and Reasonable Charges.

d. treatment, unless such treatment service or supply is provided for the treatment or diagnosis of an accidental bodily injury or sickness and is prescribed by or made at the direction of a Physician or Healthcare Practitioner, **except** as otherwise specifically provided for herein.

e. any accidental bodily injury or sickness resulting from and arising out of any employment or occupation for compensation or profit, whether or not such injury or sickness would entitle the Participant to receive benefits under workers' compensation or employers' liability law.

f. hearing aids or the fitting thereof, or repair of any hearing aid.

g. eye examinations or refractions, eye glasses, contact lenses or fitting of eye glasses or contact lenses, **except** as otherwise provided in either section 4.05, p., 8. (Page 64) or Vision Benefits (Page 69).

h. routine health examinations, **except** as otherwise specifically provided under Preventive Care in section 4.05, m. (Page 62).

i. elective termination of pregnancy (abortion), **unless** Medically Necessary to preserve the life of the mother or that the child be born with significant congenital deformity or defect, or medical complications which arise from an abortion.

j. routine dental services and supplies except for treatment or damage to natural teeth which have not been extensively restored or become extensively decayed or diseased, if the damage results from an accident and the charges are incurred within six (6) months from the date of the accident. Notwithstanding the previous sentence, all costs associated with routine dental services performed in a Hospital that are not among the types of services covered under the Plan's self-funded dental benefits will be covered for those Dependents five (5) years of age or younger.

k. cosmetic, or plastic surgery (**except** plastic, cosmetic or reconstructive surgery due to a condition caused by a malignancy or as specifically described in section 4.05, r. on Page 64), or surgery for developmental malformations or as the result of earlier cosmetic, plastic surgery, or surgery, **unless** the surgery is necessary for the repair or alleviation of damage resulting from a disability caused by accidental bodily injuries sustained by a Participant and charges are incurred within one (1) year of the accidental bodily injury or the surgery is necessary because of congenital disease or anomaly of a Dependent child which has resulted in a functional defect.

l. Custodial Care, Maintenance Care, or medical care, treatment, services or supplies for which charges are made by a nursing home, rest home, convalescent home, or similar establishment.

m. bodily injury or sickness resulting from any act of war, armed invasion or aggression, insurrection, rebellion or riot.

n. bodily injury or sickness resulting from or occurring during the commission of a felony by a Participant, or while the Participant is in the custody of any governmental agency or authority on account of an alleged commission of a felony by a Participant, if such governmental agency or authority is legally responsible for payment of such service or supply.

o. replacement or repair of any prosthetic device, **except** that replacement will be allowed once in a five (5) year period when due to a change in the individual's physical condition or if the equipment cannot be satisfactorily repaired.

p. expenses for learning deficiencies, behavioral problems and special education.

q. corrective shoes or supportive devices for the feet **unless** they are an integral part of a lower leg brace.

r. medical or surgical treatment of infertility or to reverse surgically induced infertility, sexual impotency, or genetic counseling (including testing performed specifically to determine the cause of infertility, treatment and/or procedures performed specifically to restore fertility, and artificial means of becoming pregnant, such as Artificial Insemination, In-vitro, GIFT, ZIFT, etc.).

s. humidifiers, air conditioners, purifiers, heating pads, hot water bottles, exercise equipment, whirlpools, health spa or swimming, and the like, whether or not prescribed by a Physician or Healthcare Practitioner.

t. charges incurred prior to the Participant's effective date of coverage.

u. transsexual surgery.

v. medical care, treatment or services rendered by a health care provider that ordinarily resides in the Participant's home or who is a member of the Participant's immediate family.

w. callus or corn paring; toenail trimming or excision; treatment of chronic conditions of the foot, such as weak or fallen arches, flat or pronated foot metatarsalgia, or foot strain.

x. obesity, **except** the initial examination and diagnosis, weight loss/reduction, or physical fitness programs, **except** for morbid obesity as specifically set forth in Exhibit A (Page 85).

y. disturbances of the temporomandibular joint (TMJ dysfunction/pain syndrome).

z. marital or family counseling **except** as otherwise specifically provided for under the MAP.

aa. orthoptics or vision training.

ab. care in connection with a Dependent child's pregnancy, **except** as specifically provided regarding complication of pregnancy.

ac. Radial Keratotomy (RK) or other eye surgery to correct refractive disorders.

ad. telephone, television, or personal items that do not serve a useful medical purpose.

ae. travel expenses incurred by a Participant, whether or not recommended by a Physician or travel expenses incurred by the attending Physician, **except** as relates to the transplant travel benefit.

af. transplants involving implantable and inflatable prosthesis.

ag. services rendered by a chiropractor, **except** as otherwise specifically provided for in section 4.05, q. (Page 64).

ah. substance abuse, **except** as otherwise specifically provided in section 4.05, d. (Page 60).

ai. wigs or artificial hair pieces, **except** in conjunction with otherwise covered medical treatment.

aj. court ordered classes or treatment.

ak. Laetrile; enzymes or vitamins and patent medicines that are prescription drugs and dispensed by a licensed pharmacist which are usually taken as food supplements, for general body build-up, or that are preventative in nature and not for treatment of a specific illness; over-the-counter drugs; nutritional supplements; testing devices, etc.

al. lamaze classes.

am. massage therapy, self-help and stress management.

an. speech therapy, **except** as specifically provided for in section 4.05, p., 7. (Page 64).

ao. growth hormone deficiency.

ap. Vocational Rehabilitation, **except** as specifically described in section 2.04, d., 2. (Page 53).

aq. a drug, device, medical treatment or procedure which is experimental or investigative. A drug, device, medical treatment or procedure is experimental or investigative if:

1. the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

2. the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving similar function, or if the federal law requires such review or approval; or

3. Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental study, or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

4. Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or protocol(s) utilized by other facilities studying substantially the same drug, device, medical treatment or procedure; or the written informed consent document used by the treating facility or by other facilities studying substantially the same drug, device, medical treatment or procedure.

ar. medical treatment or management of chronic pain (**except** benefits will be payable for a TENS unit and comparable units), **unless** authorized by MAP due to psychological circumstances.

as. any Hospital confinement, services or supplies unless recommended and approved by a legally qualified Physician as being necessary for proper treatment of a sickness or injury.

at. medical care or treatment received by a Participant when such Participant is enrolled in a health maintenance organization (HMO) and is eligible for such care or treatment

from such HMO, but does not utilize the services, facilities or providers covered by such an organization.

au. any surcharges a Participant incurs as a result of state laws (e.g., New York Health Care Reform Act, Massachusetts Un-compensated Care Pool Surcharge), for purposes of determining the applicable Deductible or Copayments, and over the individual's maximum annual or lifetime benefit.

av. charges for services or supplies resulting from injuries suffered by a Participant in a licensed motor vehicle accident up to **$25,000** or such higher amount as may be available for reimbursement to a Participant under licensed motor vehicle medical payment insurance coverage, whether or not the Participant has such coverage.

aw. treatment of mental or nervous disorders or substance abuse which have not been preauthorized by the MAP.

ax. reports or appearances in connection with legal proceedings whether or not an injury or illness is involved, Physician's or Healthcare Practitioner's telephone consultations and/or travel time, or charges in connection with shipping, handling, postage, interest, or finance.

ay. charges incurred through Medicare private contracting arrangements.

az. charges or claims for any medical or other treatment, service or supply to the extent that the cost of such charges may be recoverable by, or on behalf of a Participant and/or Dependent in any action at law, any judgment, compromise or settlement of any claims against any party, or any other payment, a Participant and/or Dependent, or attorney, may receive as a result of any accident, illness or Injury (collectively "Injury"), regardless of how these amounts are characterized or who pays these amounts, as provided in the "Subrogation and/or Reimbursement" section of this Plan (Pages 79-81).

As used in this section, the phrase "in connection with" means any services, treatment, supplies, or accommodations which would not be necessary but for the occurrence of the excluded type of service, treatment, supply, or accommodations.

8. COORDINATION OF BENEFITS

8.01 **Coordination of Benefits General Rules.** If a Participant is entitled to benefits from another plan for Hospital, medical or surgical care for which benefits are also due from this Plan, then the benefits provided hereunder will be paid in accordance with the following provisions not to exceed 100% of the Allowable Expenses actually incurred by the Participant. The plan under which benefits are payable first is the primary plan (or primary payer). All other plans are called secondary plans (or secondary payers). The primary plan normally pays benefits according to its schedule of Allowable Expenses. The secondary plan pays any remaining unpaid Allowable Expenses. No plan pays more than it would have without this provision.

a. Plan. The term "plan" means any plan providing benefits or services for or by reason of Hospital, surgical or medical benefits or services, which are provided in:

1. group, blanket or franchise coverage.

2. group practice and other group prepayment coverage.

3. group service plans.

4. any coverage under labor management trusteed plans, union welfare plans, employer organization plans or employee benefit organization plans.

5. any coverage under Governmental programs and any coverage required or provided by any statute.

6. any medical payments coverage available under automobile insurance policies.

The term "plan" shall not include Medicare or any individual policy or contract except as provided in b. below. Coordination of benefits with respect to Medicare is covered in section 8.03.

The term "Plan" shall not otherwise include any plan of individual insurance or School Accident Type Coverages, written on either a blanket, group or franchise basis and should not be taken into consideration for coordination of benefits. In this context, School Accident Type Coverages are defined to mean coverage for students through grade (12) for accident only including athletic injuries, whether on a 24-hour basis or "to and from school," for which the parent pays the entire premium. The term "Plan" shall be construed separately with respect to each policy, contract or other arrangement for benefits or services and separately with respect to that portion of such policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

b. Licensed Motor Vehicle Insurance. Benefits under this Plan will be coordinated, after the exclusion of $25,000 in charges as described in section 7.01, av. (Page 73), with a Participant's licensed motor vehicle medical payments coverage or with any other licensed motor vehicle insurance applicable to the state in which the Participant resides and is insured.

c. Allowable Expense. "Allowable Expense" means any Usual, Customary, and Reasonable Charges for medical care, at least a portion of which is covered under this Plan as determined by the Plan. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

d. Claim Determination Period. "Claim Determination Period" means a calendar year.

e. Coordination with HMO. This Plan shall not provide benefits for medical care or treatment available to a Participant from a health maintenance type of organization ("HMO"), when a Participant is eligible for but rejects that coverage, does not utilize the services, facilities or providers covered by the HMO, or fails to follow the HMO's rules for services.

f. Right to Information. For the purpose of determining the applicability of and implementing the terms of this coordination of benefits section of this Plan or any similar provision of any other plan, the Board of Trustees may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which the Board of Trustees deems to be necessary for such purpose. Any person claiming

benefits under this Plan shall furnish to the Board of Trustees such information as may be necessary to implement this section.

g. Right to Make Payments. Whenever payments which should have been made under this Plan in accordance with these provisions have been made under any other plan, the Board of Trustees shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this section, and amounts so paid shall be deemed to be benefits paid under this Plan. The Board of Trustees shall be fully discharged from liability under this Plan to the extent of such payments.

h. Right to Recover Payments. Whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of these provisions, the Board of Trustees shall have the right to recover such payment, to the extent of such excess, from among one (1) or more of the following as the Board of Trustees shall determine:

   1. any persons to, or for, or with respect to whom such payments were made.

   2. any other insurance companies.

   3. any other organizations.

8.02 Order of Benefit Determination (other than Medicare). The rules establishing the order of benefit determination for plans other than Medicare (which is covered in section 8.03) are as follows:

a. A plan that does not have a coordination of benefits provision is always primary and pays first.

b. A plan that covers the individual as an employee is primary. If the individual is covered as an employee under two (2) plans, the plan which has covered him the longer is primary.

c. A plan that covers the individual as an active employee (or active employee's dependent) is primary and pays before a plan that covers the individual as a laid-off employee or as a retiree (or such individual's dependent). This does not apply if either plan does not have a provision regarding laid-off or retired employees.

d. A plan that covers the individual as an employee or retiree (or such individual's dependent) is primary and pays before a plan that provides the individual (or such individual's dependent) coverage under COBRA or other continuation coverage under federal law (e.g., USERRA).

e. 1. When a Dependent child is covered under this Plan and as a dependent under another plan, the primary plan is the plan of the parent whose birthday is earlier in the year if:

      (a) the parents are married;

      (b) the parents are not separated (whether or not they ever have been married); or

(c) a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.

If both parents have the same birthday, the plan that has covered either of the parents longer is primary.

2. If the parents are not married or are separated (whether or not they ever were married) or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and the parents' spouses (if any) is:

(a) the plan of the custodial parent;

(b) the plan of the spouse of the custodial parent;

(c) the plan of the non-custodial parent; and then

(d) the plan of the spouse of the non-custodial parent.

3. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's plan is primary. This subparagraph shall not apply with respect to any Claim Determination Period or Plan Year during which benefits are paid or provided before the plan has actual knowledge.

f. When the rules above do not establish an order of benefit determination, the plan which has covered the individual for the longer period of time shall be primary.

8.03 Coordination with Medicare.

a. The Plan Primary to Medicare for Employee or Spouse Age Sixty-Five (65) or Older.

1. Benefits shall be payable under this Plan without regard to a Participant's entitlement or potential entitlement to Medicare provided such Participant is:

(a) an Active Employee or Non-Bargaining Employee age sixty-five (65) or older; or

(b) the spouse age sixty-five (65) or older of an Active Employee or Non-Bargaining Employee.

Absent an election (described in 2. below), the Plan will be the primary payer of medical costs for Active Employees, Non-Bargaining Employees and spouses over age sixty-five (65) of active Participants of any age, with Medicare providing secondary coverage. This means the Participant will be reimbursed first under this Plan (except in the case of End Stage Renal Disease ("ESRD", as set forth in c. below). If there are covered expenses not paid by the Plan, Medicare may reimburse them if the expenses are covered by Medicare. To obtain reimbursement from Medicare, the Participant must enroll for Medicare. In addition, to obtain coverage under Part B of Medicare, the Participant must enroll and pay a monthly premium to Medicare.

2. A Participant age sixty-five (65) or older is entitled to elect Medicare as the primary insurance coverage instead of the Plan. However, an Active Employee or Non-Bargaining Employee over age sixty-five (65) or a spouse over age sixty-five (65) will automatically continue to be covered by this Plan as the primary insurer unless the Participant notifies the Administrator, in writing, that he/she does not want coverage under this Plan or they cease to be eligible for coverage under this Plan. If the Participant elects primary coverage under Medicare, the Plan will not pay benefits secondary to Medicare. If you have any questions about the coordination of benefits under the Plan with Medicare benefits, contact the Claims Administrator.

3. If an Active Employee, Non-Bargaining Employee or eligible Dependent is under age sixty-five (65) and entitled to Medicare due to disability (other than ESRD), the Plan will pay benefits as primary.

b. The Plan Secondary to Medicare In All Other Cases.

1. Coordination of Benefits. When subsection (a) above does not apply (e.g., the Participant is a Retiree instead of an Active Employee) this Plan will be the secondary plan, that is, benefits are payable under this Plan after Medicare has paid the Medicare benefit. Allowable Expenses shall be reduced so that the sum of benefits paid under this Plan and Medicare combined shall not exceed the total of such Allowable Expenses.

Example (assumes that Medicare and Plan Deductibles are met):

Allowed Charges	$1,100	
Medicare payment	$ 600	
Plan payment	$ 280	($1,100 X 80% coinsurance = $880 - $600 = $280)
Participant payment	$ 220	(20% coinsurance)

If an individual is covered by both this Plan and a Medicare Advantage program (HMO), and obtains medical services or supplies in compliance with the rules of that program, including, without limitation, obtaining all services in-network when the Medicare Advantage program (HMO) requires it, this Plan will reimburse all applicable Copayments.

2. All Persons Eligible Considered Enrolled. Benefits shall be considered payable by Medicare for purposes of this section 8.03 ***whether or not the Participant eligible for Medicare benefits has enrolled in or applied for benefits under Medicare Part A and/or Part B, or has failed to take any other action required by Medicare to qualify for benefits***, or would have received benefits payable by Medicare had the Participant received services in a facility to which Medicare would have paid. In the event a Participant enters into a private contract with a Physician in accordance with Medicare private contracting arrangements, this Plan shall not coordinate benefits or assume a primary payer position on any such Participant.

Example (assumes that Medicare and Plan Deductibles are met):

Allowed Charges	$1,100	
Medicare payment	$ 0	
Plan payment	$ 280	($1,100 X 80% coinsurance = $880 - $600 = $280)
Participant payment	$ 820	($600 disallowed + 20% coinsurance)

c. End Stage Renal Disease ("ESRD"). If a Participant or eligible Dependent is entitled to Medicare on the basis of age or disability and becomes entitled to Medicare based on ESRD, the Plan will remain primary for the first thirty (30) months of entitlement to Medicare due to ESRD. If the Plan is currently paying benefits secondary to Medicare, the Plan will remain secondary upon entitlement to Medicare due to ESRD.

d. Medicare Part D. During any period in which this Plan receives the Retiree Drug Subsidy allowed under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, this Plan will not coordinate with Part D coverage and will terminate coverage under the Plan for any retired employee or Dependent of a retired employee who elects Medicare Part D coverage.

9. ALTERNATIVE CARE/LARGE CASE MANAGEMENT

9.01 Alternative Treatment. The Board of Trustees, or their designated agent, reserve the right to approve payment of benefits under the Plan, on a case-by-case basis, for alternative treatment or services received by a Participant that would otherwise not be covered under the Plan or for treatments or services provided by an alternative care facility or alternate care providers that would otherwise not be covered under the Plan, provided the following conditions are met:

a. such treatment or care was recommended by the designated agent which provides large case management services to the Plan;

b. the Participant consents in writing to such treatment or care if of legal age, or the Eligible Employee of which the Participant is a Dependent consents to such treatment or care if the Participant is not of legal age or is incapable of giving consent on a form acceptable to the Board of Trustees; and

c. it appears that such recommended care or treatment would either reduce the costs incurred by the Plan or improve the benefits realized by the Participant.

Any benefits payable under this section will be payable as if the treatment or services provided to the Participant would have been payable under other provisions of the Plan.

9.02 Types of Alternative Care. Alternative treatment or services for which the Board of Trustees may approve payment of benefits under the Plan include, but are not limited to, the following:

a. accredited rehabilitation hospital care;
b. treatment in an extended care facility; and
c. treatment in a residential care facility.

9.03 Limitations. In addition to the General Exclusions and Limitations indicated in section 7.01 (Pages 69-73), no expenses are payable under this section in excess of the total amount of expenses that would have been payable under other provisions of the Plan if the Participant had remained confined in a Hospital and the Board of Trustees had not authorized payment of such alternative treatment or services.

9.04 Availability of Alternative Care. The availability of alternative care, as otherwise set forth in this section, is not a right of the Participant or beneficiary, but a privilege which the Board of Trustees, or its designated agents, may grant upon compliance with other portions of this

section. The Board of Trustees or its designated agents retain sole discretion to deny alternative care, even if all other provisions of this section are met.

10. SELF-AUDIT PROGRAM

10.01 **Self-Audit Program.** The Plan will pay 25% of any dollars saved by the Plan, up to a maximum of $500, as a result of the Participant's review of medical bills in excess of $200 and discovery of overcharges. The Participant must contact the provider within thirty days (30) days of receipt of the bill and request a refund or corrected bill. Once the Participant has negotiated the write-off of the overcharges and obtained a corrected billing statement, the Claims Administrator will pay the Participant the appropriate amount.

11. SUBROGATION AND/OR REIMBURSEMENT

11.01 **Subrogation and/or Reimbursement.**

a. The Plan excludes coverage for any charges for any medical or other treatment, service or supply to the extent that the cost of such charges may be recoverable by, or on behalf of a Participant or Dependent(s), in any action at law, any judgment, compromise or settlement of any claims against any party, or any other payment the Participant or his/her attorney or Dependent or his/her attorney, may receive as a result of any accident, illness or Injury (collectively "Injury"), regardless of how these amounts are characterized or who pays these amounts, as provided in this section.

b. The Plan also excludes claims or charges incurred due to an Injury or disability which is compensable under workers' compensation legislation or other similar laws. However, the Plan will advance benefit payments, in an amount no greater than these allowed under the workers' compensation law (or similar laws), provided that the Participant or Dependent(s) agree to the requirements of this section, and timely apply for workers' compensation benefits (or similar benefits) with the Participant's employer and provide a copy of such application to the Plan. If the Participant's employer's workers' compensation carrier (or the employer, if it does not have insurance), denies the claim, the Participant or Dependent must appeal the denial and file a claim with the workers' compensation commission ("Commission") in the appropriate form within thirty (30) days or such shorter period provided by law, after Participant or Dependent receives the denial letter, and provides a copy of the denial and the claim with the Commission to the Plan. The Participant or Dependent must also take all action necessary to pursue the appeal or claim with the Commission, including notifying the Plan of any hearing date set by the Commission, providing the Plan with a copy of all correspondence scheduling hearing dates, and attending the hearing. The Participant or Dependent must also obtain written approval from the Plan prior to accepting any settlement for less than the full amount paid to Participant or Dependent on behalf by the Plan. The Participant or Dependent must forward a copy of the Commission's decision to the Plan within five (5) days of receipt, and if the Commission determines that the Participant or Dependent's claim is compensable or overturns the denial of the Participant or Dependent's claim, the Participant or Dependent must repay the

Plan the full amount of benefits advanced within five (5) days of having received payment.

c. The Plan is subrogated to all rights of recovery available to a Participant or Dependent arising out of any claim, demand, cause of action or right of recovery which has accrued, may accrue or which is asserted in connection with any such Injury, to the extent of any and all related benefit payments made or to be made by the Plan on behalf of the Participant or Dependent. The Plan has an independent right to bring an action in connection with such Injury in the Participant's and/or Dependent's name and has a right to intervene in any such action brought by a Participant or Dependent, including any action against an insurance carrier under any uninsured or under-insured motor vehicle policy. If a Participant or Dependent chooses not to pursue the liability of a third party, the acceptance of benefits from the Plan authorizes the Plan to litigate or settle any claims against the third party on behalf of the Participant or Dependent. If the Plan takes legal action to recover payments, the acceptance of benefits obligates the Participant, Dependent, and his/her attorney, to cooperate with the Plan in seeking its recovery, and in providing relevant information with respect to the Injury.

d. If a Participant or Dependent receives any benefit payments from the Plan for an Injury and recovers *any* amount from *any* third party or parties in connection with such Injury, the Participant or Dependent must reimburse the Plan from that recovery the total amount of all benefit payments the Plan made or will make on behalf of the Participant or Dependent in connection with such Injury.

e. The Plan's rights of reimbursement and subrogation apply regardless of the terms of the claim, demand, right of recovery, cause of action, judgment, award, settlement, compromise, insurance or order, regardless of whether the third party is found responsible or liable for the Injury, and regardless of whether the Participant or Dependent actually obtains the full amount of such judgment, award, settlement, compromise, insurance or order. The Plan's rights of reimbursement and subrogation provide the Plan with first priority to any and all recovery in connection with the Injury, whether such recovery is full or partial and no matter how such recovery is characterized, why or by whom it is paid, or the type of expense for which it is specified. Such recovery includes amounts payable under a Participant's or Dependent's own uninsured motorist insurance, under-insured motorist insurance, or any medical pay or no-fault benefits payable, provided, however, that benefits are payable under the Plan's Coordination of Benefits rules. The "make-whole" doctrine does not apply to the Plan's right of reimbursement and subrogation.

f. The Plan's rights of reimbursement and subrogation are for the *full* amount of *all* related benefits payments; this amount is not offset by legal costs, attorneys' fees or other expenses incurred by the Participant or Dependent in obtaining recovery.

g. The Plan shall have a constructive trust, lien and/or equitable lien on any amount received by a Participant, Dependent, or a representative of either the Participant or Dependent (including an attorney) that is due to the Plan under this section, and any such amount shall be deemed to be held in trust by the Participant, Dependent, or representative (including an attorney) for the benefit of the Plan until paid to the Plan.

h. A Participant or Dependent is required to notify the Plan within ten (10) days of any Injury for which any other party may be liable. The Participant or Dependent must notify within ten (10) days of the initiation of any lawsuit arising out of the Injury and within the conclusion of any settlement, judgment or payment relating to the Injury in any lawsuit initiated to protect the Plan's claims.

i. If a Participant or Dependent submits claims for or receives any benefit payments from the Plan for an Injury that may give rise to any claim against any third-party, the Participant or Dependent will be required to execute a "Subrogation, Assignment of Rights, and Reimbursement Agreement" affirming the Plan's rights of reimbursement and subrogation with respect to such benefit payments and claims. This Agreement must also be executed by the Participant's or Dependent's attorney, if applicable. Benefit payments are not payable unless a Participant signs a Subrogation Agreement, and claims will not be considered filed and will not be paid until the fully signed Agreement is received by the Plan.

j. A Participant or Dependent is obligated to take all necessary action and cooperate fully with the Plan in its exercise of its rights of reimbursement and subrogation, including notifying the Plan of the status of any claim or legal action asserted against any party or insurance carrier and of the Participant's or Dependent's receipt of any recovery. A Participant or Dependent shall take no action to impair, prejudice, or waive the Plan's rights. A Participant or Dependent should contact the Administrator if approached to settle any potential claims. These settlement offers may include provisions which would waive certain rights covering conditions under which recovery for the Plan could be received. Participants and Dependents may not waive these rights. The Plan may withhold benefits if the Participant or Dependent waives any of the Plan's rights to recovery or fails to cooperate with the Plan in any respect regarding the Fund's subrogation rights.

k. A Participant or Dependent must notify the Plan before accepting any payment from a third party prior to the initiation of a lawsuit. In the absence of such notification, the Participant or Dependent shall be required to repay the Plan, in full, for any benefits it has paid, regardless whether the amount received by the Participant or Dependent from a third party is less than the amount owed to the Plan.

l. Failure by a Participant or Dependent to reimburse the Plan from any recovery or refusal to cooperate with the Plan regarding its subrogation or reimbursement rights, shall entitle the Plan to recover the full amount of all benefits paid by methods which include, but not limited to, *offsetting the amounts paid against any future claim for benefit payments to the Participant or Dependent under the Plan*. Non-cooperation includes the failure of any party to execute a Subrogation, Assignment of Rights, and Reimbursement Agreement and the failure of any party to respond to the Plan's inquiries concerning the status of any claim or any other inquiry relating to the Plan's rights of reimbursement and subrogation.

m. If the Plan is required to pursue legal action against a Participant or Dependent to obtain repayment of benefits advanced, the Participant or Dependent will be responsible for all costs and expenses, including attorneys' fees, incurred by the Plan in connection with the collection of any amounts due hereunder or the enforcement of any rights provided for in this Plan regardless of whether a suit is filed. A Participant or Dependent will also be required to pay interest (at the rate charged on delinquent contributions owed the Plan) from the date of advance of benefits to the date that the Plan is paid the full amount owed under the Plan. By accepting benefits under the terms of this Plan, the Participant and/or Dependent agree to waive any applicable statute of limitations defense available regarding the enforcement of any of the Fund's rights to reimbursement.

12. SELF-FUNDED DENTAL BENEFITS

12.01 **Dental Benefits.** Dental benefits are provided through an Administrative Agreement with Delta Dental of Colorado, dated January 1, 1997, as amended from time to time. The Administrative Agreement establishes the level of benefits and administrative procedures for dental benefits.

The following is only a summary of the dental benefits. Dental benefits are described more fully, including limitations and exclusions, in a separate dental booklet available from the Administrator.

SUMMARY OF DENTAL PLAN BENEFITS	PPO Dentist		Delta Dental Premier or Non-Participating Dentist	
Annual Dental Plan Benefit Maximum	**$1,000 per person**			
Deductible	None		None	
Covered Services	Plan Pays	You Pay	Plan Pays	You Pay
DIAGNOSTIC & PREVENTIVE BENEFITS				
Diagnostic & Preventive Services – Used to diagnose and/or prevent dental abnormalities or disease (includes exams, cleanings and Fluoride treatments)	100%	0%	100%	0%
Dental X-Rays – X-rays	100%	0%	100%	0%
Sealants – Used to prevent decay of pits and fissures of permanent back teeth	100%	0%	100%	0%
BASIC 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%
Basic Restorative Services – Used to repair teeth damaged by disease or injury (for example, fillings)	80%	20%	80%	20%

SUMMARY OF DENTAL PLAN BENEFITS	PPO Dentist		Delta Dental Premier or Non-Participating Dentist	
Covered Services	Plan Pays	You Pay	Plan Pays	You Pay
MAJOR BENEFITS				
Relines and Repairs – Relines and repairs to bridges and dentures	50%	50%	50%	50%
Special Restorative Services – Used when teeth can't be restored with another filling material (for example, crowns)	50%	50%	50%	50%
Prosthodontic Services – Used to replace missing natural teeth (for example, bridges and dentures)	50%	50%	50%	50%

Orthodontia is not covered.

Important: Non-Participating Dentists are allowed to balance bill. Employees and/or Dependents are responsible for the difference between the non-participating Maximum Plan Allowance and the full fee charged by the Dentist.

Under the Delta Dental PPO plan, you may visit any Dentist of your choice. There are three levels of Dentists to choose from who are located nationwide:

PPO Participating Dentist

Advantages of seeing a PPO Dentist include:

- Payment is based upon the PPO Dentist's Allowable fee, or the fee actually charged, whichever is less.
- You are only responsible for any applicable deductible and coinsurance for covered procedures.

You will receive the best benefits available on this plan by choosing a PPO Dentist.

Premier Participating Dentists (Non-PPO)

You have the option of seeing a Premier Dentist, but you may incur additional costs:

- Payment is based upon the Premier Maximum Plan Allowance, or the fee actually charged, whichever is less.
- You are responsible for only applicable deductible and coinsurance for covered procedures.

Colorado counties without PPO or Premier Providers are Bent, Crowley, Custer, Gilpin, Hinsdale, Jackson, Kiowa, Mineral, Phillips, Rio Blanco, Saguache, San Juan, San Miguel and Sedgwick.

Non-Participating Dentist (Non-PPO)

You have the option of seeing a non-participating Dentist, but you may incur additional out-of-pocket costs.

- You may be responsible for payment in full to the Dentist and for filing your claim with Delta Dental for reimbursement.
- You are responsible for the difference between the non-participating Maximum Plan Allowance and the full fee charged by the Dentist.

COVERED AMOUNT means

- For PPO Dentists, the lesser of the PPO Dentist's Allowable fee or the fee actually charged.
- For Premier Participating Dentists, the lesser of the Premier Maximum Plan Allowance, or the fee actually charged.

For all other Dentists, the lesser of the Non-Participating Maximum Plan Allowance, or the fee actually charged.

For additional information you may contact Delta Dental at 303-741-9305 or 1-800-610-0201.

13. LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

13.01 **Life and AD&D Insurance.** Life and Accidental Death and Dismemberment Insurance is underwritten by Union Labor Life Insurance Company. These benefits are described in a separate booklet. Refer to the Union Labor Life certificate booklet for a complete description of the Life and Accidental Death and Dismemberment benefits.

EXHIBIT A

MORBID OBESITY GUIDELINES

Benefits will only be allowed for the treatment of obesity when (1) the condition is determined to be endogenous (described below) and (2) the person is considered to be morbidly obese according to the Body Mass Index (BMI) scale. These criteria are described below:

Endogenous Obesity

Exogenous obesity (usually caused by overeating) is not considered a qualified illness, and as such, treatment for this condition would not qualify as a covered expense under the Plan. However, it may be necessary to rule out a glandular (or endogenous) cause for the obesity. In such cases, benefits may be allowed for the initial examination, and each lab test (i.e. CBC, urinalysis, etc.).

Body Mass Index (BMI)

The BMI scale takes into account both a person's height and weight in determining the severity of a person's weight and how much of a health risk it poses. To calculate BMI, divide a person's weight in kilograms by his or her height in meters squared; or multiply the person's weight in pounds by 704 and divide that amount by his or her height in inches squared. The scale to determine the degree of obesity is as follows:

Classification	BMI score
Normal	19-24
Overweight	25-29
Obese	30-39
Morbid (or Extreme) Obesity	40 and above

Benefit

There is a lifetime maximum benefit of **$30,000** for the treatment of morbid obesity.

Treatments must be prescribed by a Physician and benefits will not be allowed unless written authorization is received in advance from the Claims Administrator. All other benefit plan provisions (i.e., medical necessity, UCR, PPO/non-PPO will apply).

Course of treatment may include:

1. Prescription drugs;
2. education by a dietician or nutritionist;
3. surgical treatments like gastric stapling, intestinal bypass; and
4. behavioral modification and/or psychological support through behavioral health counseling and support groups.

Exclusions

The following services are specifically excluded:

1. Medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity.
2. Weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.

SECTION III

GENERAL PROVISIONS

GENERAL PROVISIONS

1. **Workers' Compensation**. The benefits provided by this Plan are not in lieu of and do not affect any requirement for coverage by worker's compensation insurance laws or similar legislation.

2. **Trust Agreement**. The provisions of this Plan Document are subject to and controlled by the provisions of the Trust Agreement, and in the event of any conflict between the provisions of this Plan Document the provisions of the Trust Agreement, the provisions of the Trust Agreement shall prevail.

3. **Plan Interpretation and Determinations**. With respect to those benefits that are provided directly by the Fund, the Board of Trustees shall have exclusive authority and discretion to determine whether a claimant is eligible for any payments under this Plan; to make factual determinations about any matter under the Plan; to determine the amount of payment, if any, a claimant is entitled to under this Plan; to interpret all of this Plan's provisions; and to interpret all of the terms used in this Plan. All such determinations and interpretations made by the Trustees, or their designee, are final and binding upon any person claiming benefits under this Plan; and shall be given deference in all courts of law, to the greatest extent allowed by applicable law; and shall not be overturned or set aside by any court of law unless found to be arbitrary and capricious.

4. **Amendment and Termination**. The Board of Trustees intends to continue the Plan as long as contributions permit. Nevertheless, the Board of Trustees reserves the right, in its sole judgment, to terminate or amend the Plan, or any part of it, including the types and amounts of benefits, at any time. The Trustees also reserve the right to amend the eligibility rules. Participants, including retirees, do not have a vested right to benefits under the Plan.

   In the event the Plan is terminated, the Board of Trustees will use remaining assets of the Fund to provide benefits, pay administration expenses and otherwise to carry out the purposes of the Plan in an equitable manner until the entire remainder of the Fund has been disbursed as provided in the Trust Agreement.

5. **Disclaimer**. With the exception of benefits guaranteed under a contract of insurance, there is no liability on the Board of Trustees or any other individual or entity to provide payment over and beyond the amounts in the Fund collected and available for such purpose.

6. **Titles**. Title of provisions are for convenience of reference only and are not to be considered n interpreting this Plan.

7. **Gender**. Wherever any words are used in this Plan in the masculine gender, they should be construed as though they were also used in the feminine gender in all situations where they would so apply; wherever any words are used in the Plan in the singular form, they should be construed as though they were also in the plural form in all situations where they would so apply, and vice versa.

8. **Non-Reversion and Employer Refunds**. It is expressly understood that in no event shall any of the corpus or assets of the Plan revert to the Contributing Employers or be subject to any claims of any kind or nature by the Contributing Employers or Eligible Employees, except for employee benefits made available to Eligible Employees under the Plan, provided, however, that contributions made by a Contributing Employer by mistake may be returned to such Contributing Employer upon request within six (6) months after the Plan Administrator

determines that the contribution was made by such a mistake subject to policies and procedures adopted by the Board of Trustees.

9. **No Vested Rights**. No Participant, employee, retiree, Dependent or beneficiary of a Participant, or any other person shall have any vested right to any benefit(s) provided by the Plan.

10. **Payment of Claims.** All covered benefits will be paid by the Plan to the Participant as they accrue upon receipt of written proof satisfactory to the Plan, covering the occurrence, character and extent of the event for which the claim is paid.

11. **Assignment of Benefits.** A Participant does not have the right to assign benefit payments to the provider of medical services. The Fund may, in its discretion, allow assignment of previously approved benefit payments to the actual service provider. It may also, it its discretion, elect to pay claims directly to a service provider even when it has not expressly approved an assignment but may stop such payments at any time it elects to do so. No Participant, or beneficiary, and no service provider may rely on the fact of prior payment as a basis to expect future payments directly to a service provider. However, the Fund will not recognize a purported assignment if any questions exist as to the eligibility for benefits, nor will it recognize any purported assignments to any person or entity other than the actual service provider under any circumstances. The Fund may, in its discretion, allow automatic assignment to Preferred Providers.

12. **Facility of Payment.** In the event the Plan determines that the Participant is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the participant has not provided the Plan with the address at which he/she can be located for payment, the Plan may, during the lifetime of the Participant, pay any amount otherwise payable to the Participant to the husband or wife or relative by blood of the Participant, or to any other person or institution determined by the Plan to be equitably entitled thereto; in the case of the death of the participant before all amounts payable under the Plan have been paid, the Plan may pay any such amount to any person or institution determined by the Plan to be equitably entitled thereto.

The remainder of such amount shall be paid to one (1) or more of the following surviving relatives of the Participant: lawful spouse, child or children, mother, father, brothers or sisters, or to the Participant's estate, as the Board of Trustees in its sole discretion may designate. Any payment in accordance with this provision shall discharge the obligation of the Plan hereunder to the extent of such payment.

13. **Proof Of Claim.** The Plan, at its own expense, shall have the right and opportunity to examine the person of any Participant when and so often as it may reasonably require during the pendency of any claim. Proof of claim forms, as well as other forms, and methods of administration and procedure will be solely determined by the Plan.

14. **Submission of Falsified or Fraudulent Claims**. All claims or enrollment cards submitted to the Plan shall be honest, accurate and as complete as possible. If the Board of Trustees finds, at any time, that there has been an intentional falsification of any document submitted in support of a claim, either by use of forgery or intentionally inaccurate information or any other fraudulent means whatsoever, it shall have the right to immediately terminate coverage and/or refuse to honor any claim which is related to the falsified or fraudulent information. The coverage to be terminated, if the Board of Trustees so determines, shall be that of the Eligible Employee and Dependents who are related to the person submitting the false or fraudulent claim.

15. **Attorney's Fees**. The Participant or health care provider shall be liable for collection costs, including court costs, witness fees, and reasonable attorneys' fees, if, after demand for

payment by the Plan, the individual or health care provider fails to pay to the Plan any excess payments paid by the Plan resulting from claims payment made in error or fails to pay any money due the Plan under the Subrogation clause in section 9.22 hereof.

16. **Right to Recovery/Overpayments**. If the Plan pays benefits in error, such as where the Plan pays a Participant, including a Dependent, more benefits than the individual is entitled to, or if the Plan advances benefits that a Participant, including a Dependent, is required to reimburse either because he or she has received a compensable workers' compensation claim or has received a third party recovery (see "Subrogation and/or Reimbursement" and "General Exclusions and Limitations" in Section II), the Plan shall be entitled to recover such benefit payments (hereafter "Overpayments"). The Plan may recover Overpayments by offsetting all future benefits otherwise payable by the Plan on behalf of the Participant and his or her Dependents. For example, if the Overpayment was made to an Eligible Employee, the Plan may offset the future benefits payable by the Plan to the Eligible Employee and his or her Dependents. If the Overpayment was made to a Dependent, the Plan also may offset the future benefits payable by the Plan to the Eligible Employee and his or her Dependents. The Plan may also seek recovery from other insurers, any institution, Physician or other provider of medical care or any other organization when payments for claims made by the Plan are more than the amount payable under this Plan Document.

The Plan shall have a constructive trust, lien and/or an equitable lien by agreement in favor of the Plan on any Overpayment, including amounts held by a third party, such as an attorney. Any such amount will be deemed to be held in trust by the Participant, Dependent, or third party for the benefit of the Plan until paid to the Plan. By accepting benefits from the Plan, a Participant and Dependent agree that a constructive trust, lien, and/or equitable lien by agreement in favor of the Plan exists with regard to any Overpayment. A Participant and Dependent agree to cooperate with the Plan by reimbursing all amounts due and agree to be liable to the Plan for all of its costs and expenses, including attorneys' fees and costs, related to the collection of any Overpayment and agree to pay interest at the rate determined by the Trustees from time to time from the date of the Overpayment through the date that the Plan is paid the full amount owed.

In addition to the right to recover Overpayments by offset, the Plan also has the right to recover Overpayments by pursuing legal action against the party to whom the benefits were paid or the party on whose behalf they were paid. In that event, the party to whom benefits were paid or the party on whose behalf they were paid shall pay all costs and expenses, including attorneys' fees and costs, incurred by the Plan in connection with the collection of any Overpayment or the enforcement of any of the Plan's rights to repayment. By accepting benefits from the Plan, a Participant and Dependent agree to waive any applicable statute of limitations defense available to the Participant and Dependent regarding the enforcement of any of the Plan's rights to recoup Overpayments.

17. **Right to Information**. For the purpose of determining the applicability of and implementing the terms of this Plan, the Board of Trustee may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization or person, any information, with respect to any person, which the Board of Trustees deems to be necessary for such purpose. Any person claiming benefits under this Plan shall furnish to the Board of Trustees such information (for example, birth, marriage, or death certificates, court orders, divorce decrees, adoption papers, tax returns, etc.) as may be necessary to administer this Plan.

18. **Independent Medical Review.** The Plan maintains the right to submit any Participant's claim to an independent medical review, at the Plan's expense.

SECTION IV

PLAN INFORMATION AND ERISA RIGHTS

PLAN INFORMATION AND ERISA RIGHTS

NAME AND TYPE OF ADMINISTRATION OF THE PLAN

The Colorado Sheet Metal Workers' Local 9 Family Health Plan is a collectively-bargained, jointly-trusteed Labor-Management Trust, and is a group health plan.

NAME AND ADDRESS OF THE PERSONS DESIGNATED AS AGENT FOR THE SERVICE OF LEGAL PROCESS

The Board of Trustees is designated as the agent for service of legal process, therefore legal process may be served on any Plan Trustee. Their names and addresses are listed below.

NAME AND ADDRESS OF THE PLAN ADMINISTRATOR

The Board of Trustees is the Plan Administrator.

The Administrator named below performs the routine administration of the Plan:

Mary Martin
Mailing Address: P.O. Box 27910, Denver, Colorado 80227-0910
Street Address: 7510 West Mississippi, Suite 200,Lakewood, Colorado 80226
Telephone: (303) 922-1213 extension 14
1 (888) 831-1213

NAMES, TITLES AND ADDRESSES OF TRUSTEES

EMPLOYEE TRUSTEES
John Fleck, Business Representative
Sheet Metal Workers' Local No. 9
7510 W. Mississippi
Suite 200
Lakewood, Colorado 80226

Dwayne Stephens, Business Manager
Sheet Metal Workers' Local No. 9
7510 W. Mississippi
Suite 200
Lakewood, Colorado 80226

EMPLOYER TRUSTEE
Thomas P. Keating, Executive Director
SMACNA
1114 W. 7th Avenue
Suite 220
Denver, Colorado 80204

COLLECTIVE BARGAINING AGREEMENTS

The Plan is maintained pursuant to collective bargaining agreements. The collective bargaining agreements require contributions to the Plan based on fixed hourly rates. A copy of any applicable collective bargaining agreement may be obtained by Participants and beneficiaries upon written request to the Administrator, and is available for examination by Participants and beneficiaries at the Administrator's Office.

The Administrator will provide you, upon written request, information as to whether a particular employer is contributing to this Plan on behalf of Participants working under the collective bargaining agreement.

PLAN YEAR

The Plan Year is January 1 - December 31.

INTERNAL REVENUE SERVICE PLAN IDENTIFICATION NUMBER

84-6029106.

PLAN NUMBER

501.

TRUST FUND

Benefits are provided from the Fund's assets which are accumulated under the provisions of the collective bargaining agreement and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered Participants and defraying reasonable administrative expenses.

THE SPONSOR OF THE PLAN

The sponsor of the Plan is the Board of Trustees.

ELIGIBILITY AND BENEFITS

The Plan's requirements respecting eligibility for participation, the conditions pertaining to eligibility to receive benefits, and a description of the benefits are included in this combined Plan and Summary Plan Description (except for Life Insurance and Accidental Death and Dismemberment Insurance and Dental benefits, which are described in separate booklets).

CIRCUMSTANCES WHICH MAY AFFECT BENEFITS

Circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture or suspension of any benefits are included in this combined Plan and Summary Plan Description.

SOURCE OF FINANCING OF THE PLAN AND ORGANIZATIONS THAT PROVIDE BENEFITS

Benefits are provided from the Fund's assets which are accumulated under the provisions of the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered participants and defraying administrative expenses.

All of the types of employee welfare benefits provided by the Plan are set forth below. Some benefits are provided directly under a group insurance policy or contract with an insurance company, administrative office or claims processing company. The following chart explains whether a particular benefit is provided directly by the Trust or another entity, and the name and address of any claims administrator or insurance company. For the benefits provided through a contract with an insurance company the benefits are guaranteed and paid through the insurance contract and the insurance company provides claims processing services for the benefits.

Benefit Type	Claims Administrator Type of Administration	Source of Benefits and Type of funding
Comprehensive Medical, Prescription Drug and Vision Benefits Welfare group health plan Account #3317508	Contract Administration for eligibility Fringe Benefit Services, Inc. P.O. Box 21240 Denver, CO 80221-0240 303-427-5580 1-888-900-5580 Contract Administration for PPO Network and Claims Administration: CIGNA HealthCare 3900 E. Mexico Avenue, Suite 1250 Denver, CO 80210 303-691-1014 1-800-244-6224	Self-funded from Trust Fund assets and participant self-payments
Dental Group #1883	Contract Administration Delta Dental Plan of Colorado P.O. Box 173803 Denver, CO 80217-3803 303-741-9305 1-800-610-0201	Self-funded from Trust Fund assets and participant self-payments
Employee Life Insurance, Dependent Life Insurance, Accidental Death and Dismemberment Policy #G-8622	Insurance Administration Union Labor Life Insurance Company 111 Massachusetts Avenue, N.W. Washington, D.C. 20001 1-800-431-5425	Fully Insured
Mental Health/ Substance Abuse	Contract Administration Mines and Associates 10367 W. Centennial Rd. Littleton, CO 80127 303-832-1068	Self-funded from Trust Fund assets and participant self-payments
Accident and Sickness Weekly Benefits	Contract Administration Fringe Benefit Services, Inc. P.O. Box 21240 Denver, CO 80221-0240 303-427-5580 1-888-900-5580	Self-funded from Trust Fund assets and participant self-payments

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

The Plan will provide dependent coverage to a child if it is required to do so under the terms of a *Qualified Medical Child Support Order ("QMCSO")*. The Plan will provide coverage to a child under a *QMCSO* even if the Participant does not have legal custody of the child, the child is not dependent upon the Participant for support, and regardless of enrollment season restrictions which otherwise may exist for dependent coverage. If the Plan receives a *QMCSO* and the Participant does not enroll the affected child, the Plan will allow the custodial parent or state agency to complete the necessary enrollment forms on behalf of the child. A copy of the Plan's procedures for determining whether an order is a *QMCSO* can be obtained from the Administrator.

A *QMCSO* may require that weekly disability benefits payable by the Plan be paid to satisfy child support obligations with respect to a child of a Participant. If the Plan receives such an order and benefits are currently payable or become payable in the future while the order is in effect, the Plan will make payments either to the Child Support Agency or to the recipient listed in the order.

RIGHTS OF PLAN PARTICIPANTS

As a participant in the Colorado Sheet Metal Workers' Local 9 Family Health Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites, all documents governing the Plan including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The administrator may make reasonable charge for the copies.

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

CONTINUE GROUP HEALTH PLAN COVERAGE
Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

PRUDENT ACTIONS BY PLAN FIDUCIARIES
In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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

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

qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ADMINISTRATOR
COLORADO SHEET METAL WORKERS' LOCAL 9
FAMILY HEALTH PLAN

Mailing Address: P.O. Box 27910
Denver, Colorado 80227-0910
Street Address: 7510 West Mississippi, Suite 200
Lakewood, Colorado 80226
Telephone: (303) 922-1213, extension 14
or
Toll free 1-888-831-1213

CLAIMS ADMINISTRATOR
CIGNA HealthCare
1-800-244-6224
www.cigna.com

CONSULTANTS AND ACTUARIES
THE SEGAL COMPANY

LEGAL COUNSEL
SLEVIN & HART, P.C.

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