# Summary Plan Description

**of the**

# HEALTH AND WELFARE PLAN

**provided through the**

# SHEETMETAL WORKERS LOCAL UNION NO. 32 HEALTH AND WELFARE FUND

**Effective July 1, 2018**

# SHEETMETAL WORKERS LOCAL UNION NO. 32
# HEALTH AND WELFARE FUND

# HEALTH AND WELFARE PLAN

**To All Eligible Participants:**

We are pleased to present this updated booklet, the Summary Plan Document ("SPD"), which describes the major features of the Health and Welfare Plan ("the Plan") offered through the Sheetmetal Workers Local Union No. 32 Health and Welfare Fund ("the Fund"). The Plan is managed and operated by the Fund's Board of Trustees and is designed so that you can receive the most comprehensive benefits possible within the resources available to the Fund.

This booklet is an easy-to-read description of the Plan. It describes eligibility rules, benefits, claim procedures and information about the administration of the Plan. The Plan is governed by certain documents, including your Collective Bargaining Agreement or Participation Agreement, the Plan Document, the Trust Agreement, and agreements with insurance companies and other service providers. We have tried to describe the benefits here just as they are written in those documents. However, if there is any difference between the terms of this booklet and those of the governing documents, the governing documents or contract provisions will control. Capitalized terms in this SPD are used in the same manner as they are used in the Plan Document.

This booklet describes rules and benefits for all persons who receive benefits under the Plan, some of whom may be employed by different Employers. Your own benefits are based on the terms of your Employer's Collective Bargaining Agreement or Participation Agreement. You may not be eligible for all of the benefits described in this SPD and you may not be subject to all of the rules described. Please refer to the Schedule of Benefits and/or the Summary of Benefits and Coverage that you are given along with this booklet for information about your benefits.

Please keep this booklet in a safe place for quick reference. If you have any questions about your eligibility or the benefits to which you are entitled, please contact the Plan's Third Party Administrator, National Employee Benefits Administrators at 1-800-842-5899.

Sincerely,

**BOARD OF TRUSTEES**

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# HEALTH AND WELFARE PLAN OF SHEETMETAL WORKERS LOCAL UNION NO. 32 HEALTH AND WELFARE FUND

***A Multiemployer Health and Welfare Benefit Plan***

## IMPORTANT INFORMATION

The Plan is sponsored and administered under the joint control of labor and management trustees. The Board of Trustees consists of both Union and Employer representatives, selected by SHEET METAL WORKERS LOCAL UNION NO. 32 and the Employers who have entered into Collective Bargaining Agreements with SHEET METAL WORKERS LOCAL UNION NO. 32 requiring contributions to the Plan for the benefit of their Employees.

The Plan is sponsored by the:

***BOARD OF TRUSTEES***

*Members, as of July 1, 2018:*

Union Trustees

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Sheet Metal Workers LU 32
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North Miami Beach, FL 33179-2709
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2530 Ali Baba Avenue
Opa Locka, FL 33054
jrudisill@bsasheetmetal.com
(305) 681-3771

The Plan is administered by the **BOARD OF TRUSTEES** with the assistance of the:

## *THIRD PARTY ADMINISTRATOR*

National Employee Benefits Administrators, Inc. ("NEBA")
2010 N.W. 150th Avenue, Suite 100
Pembroke Pines, Florida 33028
1-800-842-5899

The Third Party Administrator ("NEBA") handles day to day administration for the Plan.

The Board of Trustees is the Plan Administrator.

## *PLAN IDENTIFICATION INFORMATION*

Federal Identification Number: 65-6088549

Plan Number: 501

## *PLAN YEAR*

The Plan Year is based on the 12-month period from July 1 to June 30 each year.

## *FUND COUNSEL and AGENT FOR LEGAL PROCESS*

Sugarman & Susskind, PA
100 Miracle Mile, Suite 300
Coral Gables, Florida 33134

*Service of Process may also be made upon a Plan Trustee or upon the Board of Trustees, as the Plan Administrator, c/o NEBA.*

# GENERAL PLAN DESCRIPTION

### *Health and Welfare Benefit Plan*

The **Health and Welfare Plan of Sheetmetal Workers Local Union No. 32 Health and Welfare Fund ("the Plan")** is an employee benefit plan that provides medical, prescription drug, dental, vision and loss of time benefits to participants as provided under the terms of applicable Collective Bargaining Agreements or Participation Agreements. The Plan is subject to and complies with the provisions of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended.

### *Funding Sources for Benefits*

The Plan is primarily funded by Employer contributions made as required under the terms of applicable Collective Bargaining Agreements and Participation Agreements. Some covered individuals may be required to contribute towards the cost of their coverage under the terms of the applicable Agreements. All contributions are held in a Trust Fund managed by the Board of Trustees as provided in the Trust Agreement. The Trust Fund's assets include all contributions and investment earnings. All benefits and expenses of the Plan, including premiums for any insurance policies obtained by the Board of Trustees as the method of providing benefits, are paid using Trust Fund assets.

## *Rights and Responsibilities of the Board of Trustees*

The Board of Trustees has full and exclusive power and authority, in its sole discretion, to:

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

Any decisions of the Board of Trustees shall be final and binding on all parties, including Employees, Retirees, Dependents, beneficiaries, Employers, Unions, and all other persons involved or affected. In addition to the Board of Trustees the Plan may have other fiduciaries, advisors and service providers. The Board of Trustees may allocate fiduciary responsibility among the Plan's fiduciaries and may delegate responsibilities to others.

## *Plan Amendment and Termination*

The Plan may be amended by the Trustees, in their discretion, upon majority vote of the Trustees. All amendments shall be in writing and signed by the Trustees.

The Board of Trustees expressly reserves the right, in its sole discretion, at any time and from time to time:

(a) to terminate or amend either the amount or conditions with respect to any benefits even though such termination or amendment affects claims which have already been incurred;
(b) to alter or postpone the method of payment of any benefit; and
(c) to amend or rescind any other provisions of the rules and regulations contained herein.

Circumstances under which the Plan may be terminated include, but are not limited to:

(a) When there are no longer sufficient assets to continue the benefits of the Plan.
(b) When there are no longer any Employers who are required to make contributions under an applicable Collective Bargaining Agreement; or
(c) When the last surviving Covered Person entitled to receive benefits has died.

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

## *Right to Examine Relevant Documents*

The Plan is maintained pursuant to one or more Collective Bargaining Agreements. Collective Bargaining Agreements are contracts between an Employer and a Union that require certain health care benefits for covered Employees. Copies of such agreements may be obtained by participants and beneficiaries by submitting a written request to the Plan Administrator. Copies of the agreements are also available for examination at the office of the Third Party Administrator.

A complete list of the employers and employee organizations sponsoring this Plan may be obtained by participants and beneficiaries by submitting a written request to the Third Party Administrator. The list

is also available for examination by participants and beneficiaries at the office of the Third Party Administrator. Participants and beneficiaries may also receive from the Third Party Administrator, upon written request, information as to whether a particular employer or employee organization participates in the Plan; if the employer or employee organization does participate in the Plan then contact information is also available.

You also have the right to examine documents governing the Plan at the office of the Third Party Administrator, such as insurance contracts, and you have a right to examine the Plan's annual report (Form 5500 Series) that is filed each year.

# PERSONS ELIGIBLE FOR BENEFITS

## I. Bargaining Unit Employees

The Plan provides health care and other benefits to eligible employees (and their dependents) working under a Collective Bargaining Agreement ("CBA") that provides for benefits. The following rules apply if you are working under a CBA between your Employer and Sheet Metal Workers Local Union No. 32 or any other local or union accepted for participation in the Plan. **In order to become eligible for benefits under this Plan you must first satisfy any requirements described in your Collective Bargaining Agreement.** Most CBAs require that Employees work at least a certain number of hours or meet other conditions before your Employer is required to make contributions to the Plan on your behalf. Many CBAs also require that Employees contribute towards the cost of health care coverage by authorizing deductions from their paychecks. Please consult your CBA, or talk to your Employer or Union, to find out your specific requirements. Once you have satisfied the terms of your CBA your Employer will be required to make contributions to the Plan on your behalf, and you will be eligible to receive benefits, as described here.

### *Initial and Continued Eligibility*

- Once your Employer is required to pay for your health care benefits your Employer will contribute to the Trust Fund; the money in the Fund is then used to provide benefits for you and for all of the other Employees working under similar agreements with Employers who are also required to contribute to the Trust Fund. Your Employer makes a monthly contribution on your behalf, and you are covered for each month paid on your behalf, as shown on the chart.
- The month in which your Employer pays the Trust Fund is called the "Eligibility Month" and the month in which you get coverage is called the "Benefit Month". You first become eligible for coverage on the first day of the Benefit Month that corresponds to the first Eligibility Month during which your Employer made at least 130 hours of contributions on your behalf.
- You must fill out enrollment applications and provide all information requested by NEBA, the Plan's Third Party Administrator, in order to obtain and maintain coverage.
- Your Collective Bargaining Agreement might have other requirements that you may have to satisfy in order to maintain eligibility for benefits, such as contributing towards the cost of your health care coverage, which may require authorizing deductions from your paycheck, or working required hours.
- The following chart shows Eligibility Months and corresponding Benefit Months.

**ELIGIBILITY MONTHS**
**AND CORRESPONDING BENEFIT MONTHS**

| Eligibility Month | Benefit Month |
|---|---|
| January | April |
| February | May |
| March | June |
| April | July |
| May | August |
| June | September |
| July | October |
| August | November |
| September | December |
| October | January |
| November | February |
| December | March |

## *Continuation of Eligibility*

Your eligibility for coverage continues on a monthly basis from one Benefit Month to the next if contributions for at least 130 hours are timely made to the Fund on your behalf during each corresponding Eligibility Month and you satisfy any required conditions.

Even if you do not work 130 hours during an Eligibility Month, you may be entitled to have the necessary 130 hours of contributions made on your behalf by one of the following ways: 1) By using hours saved in your Hour Bank; 2) By making Self-contributions; 3) By receiving disability credit hours.

Hour Bank: Once you have satisfied initial eligibility for coverage you are eligible for an hour bank account. Any hours in excess of 140 that an Employer reports for you during an Eligibility Month will be credited to your hour bank account. The maximum accumulation in an hour bank account is 780 hours.

If you have less than 130 hours reported and paid on your behalf for an Eligibility Month, then the Plan Administrator will deduct the necessary hours from your hour bank account and contribute them to the Fund so that you will have 130 hours for the Eligibility Month and will be eligible for coverage in the corresponding Benefit Month.

If the difference between 130 hours and the number of hours reported and paid by your Employer on your behalf is greater than the number of hours in your hour bank, you may be eligible to make a self-contribution for the remaining necessary hours.

If you have less than 130 hours reported and paid on your behalf for an Eligibility Month, and you do not have sufficient hours in your hour bank, and you either cannot or choose not to make a self-contribution, then the hours will not be deducted from your hour bank and you will not be eligible for coverage in the corresponding Benefit Month. The remaining hours in your hour bank can subsequently be used to re-establish eligibility for benefits within 6 months from the end of the Eligibility (Work) Month. If such hours are not used within this 6-month window they are forfeited.

Your hour bank account is not a vested benefit. The hours in your hour bank account may be limited, changed or removed at any time within the discretion and control of the Board of Trustees. Hour bank accounts have no monetary value.

Self-Contribution: You are entitled to make a self-contribution for up to ten (10) hours per Eligibility Month for continuing coverage during the corresponding Benefit Month. All hour bank hours must be used to maintain eligibility prior to making a self-contribution.

The self-contribution amount is the difference between the number of hours contributed to the Fund by Employers on your behalf (and hour bank hours if applicable) and 130, multiplied by the applicable contribution rate.

You must remain in the employ of an Employer or be Available for Work with an Employer in order to make self-contributions for continued coverage. You must be an active Employee covered under the Plan at the time of the hours shortage.

Disability Credit Hours: If you become disabled while you are eligible for benefits under the Plan, you shall be credited with the total number of hours required to maintain eligibility for each calendar month of proven disability, up to a maximum of 6 months in any 12 month period.

A month of proven disability is any calendar month in which you can medically prove that you have been Totally Disabled (See the Definitions sections of this document) for at least twenty consecutive days in the month.

### *Termination of Eligibility*

Your eligibility for coverage ends on (i) the last day of the Benefit Month that corresponds to the last Eligibility (Work) Month during which contributions for the required number of hours were paid to the Plan by or on your behalf; (ii) the date that the Plan terminates or (iii) the date that you are no longer eligible for coverage by not being Available for Work or otherwise not satisfying any required conditions for coverage.

### *Reinstatement of Eligibility*

If your eligibility for benefits has terminated, your eligibility for benefits will be reinstated on the first day of the Benefit Month that corresponds to the Eligibility (Work) Month during which contributions are made on your behalf for at least 130 hours. You may use remaining hours in your hour bank to re-establish eligibility.

## II. Non-Bargaining Unit Employees

The following rules apply if you are not covered by a Collective Bargaining Agreement but are instead covered under a Participation Agreement with the Board of Trustees. A Participation Agreement is an agreement between an Employer and the Board of Trustees in which an Employer agrees to make monthly contributions to the Plan to cover its Employees who are not represented by the Union. Such employees are called "Non-Bargaining Unit Employees" because they are not members of the Union's bargaining unit. You may have to satisfy additional requirements in the Participation Agreement, or in any agreement you have with your Employer, in order to be eligible for benefits, such as contributing towards the cost of coverage by authorizing payroll deductions.

### *Initial and Continued Eligibility*

As a Non-Bargaining Unit Employee, your eligibility for coverage will be determined according to the same rules as those in Section I above for Bargaining Unit Employees. Non-Bargaining Unit Employees

are not, however, entitled to an hour bank. Also, Non-Bargaining Unit Employees may not make self-contributions to continue their eligibility for coverage.

## III. Retirees

The Plan offers retiree coverage to individuals who meet the eligibility rules and requirements below.

The Board of Trustees has full authority and power to adopt a plan of benefits and establish the contribution to be paid for retiree coverage. The Board of Trustees reserves the right to amend, modify or terminate retiree coverage at any time.

The eligibility rules and requirements for retirees are as follows:

### *Initial and Continued Eligibility*

In order to be eligible for retiree coverage under the Plan, you must have been a Covered Employee under the Plan immediately prior to your retirement from the industry, and you must be a retiree under the Sheetmetal Workers Local Union No. 32 Pension Fund or the Sheetmetal Workers National Pension Fund. You must also submit an application for benefits to the Third Party Administrator.

If you meet the above requirements, your eligibility for retiree coverage will be effective on the first day of the month following the 4-month period during which the Plan receives no contributions on your behalf.

Your continued eligibility for retiree coverage will be determined on a monthly basis. The Board of Trustees will determine from time to time the amount of the monthly contribution that Retirees must pay for retiree coverage. You will remain eligible for benefits for each month for which you make timely contributions on your behalf in the amount determined by the Board of Trustees. Retiree self-contributions must be received in the office of the Third Party Administrator no later than the 20$^{th}$ day of each month preceding the month for which coverage will be effective.

### *Termination of Eligibility*

As a Retiree, your eligibility for coverage ends on the earlier of: (i) the date as of which you are no longer "retired" as that term is defined in the Plan Document of the Sheetmetal Workers Local Union No. 32 Pension Fund or the Sheetmetal Workers National Pension Fund; or (ii) the last day of the month for which an on-time self-contribution has been made for retiree coverage; or (iii) the date of your death, though covered Dependents will continue coverage through the end of the month; or (iv) with respect to specific benefits or types of coverage, the date as of which the Board of Trustees decides to limit or eliminate same; or (v) the date you become entitled to Medicare benefits, though your spouse, if any, may continue coverage until the spouse's eligibility for Medicare; or (vi) the date as of which the Board of Trustees terminate retiree coverage under the Plan; or (vii) the date of termination of the Plan.

## IV. Dependents

The Plan offers coverage for your spouse and your children to age 26. Adult children may be covered up to age 30 under certain conditions, described below. Bargaining unit Employees, Non-Bargaining Unit Employees, and Retirees may elect dependent coverage.

Your Dependents are eligible for coverage during the same Benefit Months when you are eligible for coverage, if you've met all requirements for Dependent coverage.

## *How can you enroll your Dependents?*

All requirements in an applicable Collective Bargaining Agreement ("CBA") or Participation Agreement must be met in order for your Dependents to be eligible for benefits. You may or may not be required to pay for dependent coverage under the terms of your CBA or Participation Agreement. If you elect Dependent coverage and you are required to pay for your Dependents then you may or may not have to authorize deductions from your paychecks. You will be entitled to dependent coverage without additional contributions if it is allowed under your CBA or Participation Agreement. Contact your Employer to elect Dependent coverage and to authorize any required payroll deductions.

You must also submit an application to the Third Party Administrator, following rules established by the Third Party Administrator, in order for your Dependents to be covered under the Plan. Please file the application within thirty (30) days of your eligibility or of the date you acquired a new Dependent.

You must comply with any administrative requirements established by the Third Party Administrator in order to maintain coverage for Dependents, including providing timely information as requested by the Third Party Administrator from time to time under procedures established by the Third Party Administrator.

## *When can you enroll your Dependents?*

A person who satisfies the definition of Dependent can be covered as your Dependent as of the first day when you become eligible for benefits, or as of the first day a person becomes your Dependent, whichever is earlier.

## *When will my Dependents lose coverage?*

Your Dependents will lose eligibility for coverage on the earlier of:

(a) the date upon which you are no longer eligible for benefits;

(b) the last day of the Benefit Month that corresponds to the Eligibility Month during which your Dependent no longer satisfies the definition of a Dependent, unless a child is entitled to continued coverage under Michelle's Law, as explained in this SPD;

(c) the last day of the Benefit Month that corresponds to the last Eligibility month for which any required contributions have been timely made to the Trust Fund on behalf of your Dependent;

(d) in the event of your death, the last day of the last month for which you would have been entitled to coverage (including any available hour bank hours and self-contributions paid as of the date of death if you were covered as a Bargaining Unit Employee); or

(e) the date of termination of the Plan.

## *Who is your Dependent?*

A person must satisfy the definition of Dependent in order to be eligible for benefits as a Dependent.

*A. Dependent Defined*

The term "Dependent" as defined in the Plan Document includes:

Dependent –

(a) The married spouse or of a Covered Employee, while not divorced or legally separated from the Covered Employee.

(b) Each child of a Covered Employee, until the end of the year in which the child attains age 26, and as described further below.

(i) For the purpose of this section, the term "child" means a Covered Employee's natural child, adopted child, stepchild and/or foster child, as described in Section 152(f)(1) of the Internal Revenue Code.

(ii) In addition, "child" also means a child for whom there is a Qualified Medical Child Support Order which states that health care coverage must be maintained by a Covered Employee.

*B. Special Definition of Dependent under Florida state law*

The Florida legislature passed a law that requires insurance companies to offer extended dependent health care benefits coverage for children up to the age of 30 under certain circumstances. This requirement applies to this Plan because health benefits are provided through insurance policies.

Under Florida law an insurer must offer a covered Employee the opportunity to insure a child up until the end of the calendar year in which such child reaches the age of 30 if the child:

(a) Is unmarried and does not have a dependent of his or her own; and

(b) Is a resident of this state or a full-time or part-time student; and

(c) Is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

If a child between the ages of 26 and 30 is enrolled for health care coverage on the basis of being a full or part time student, and the child goes on a "medically necessary leave of absence", as defined in 29 U.S.C. § 1185c ("Michelle's Law"), and loses student status, the child's coverage will not be terminated before the date that is the earlier of (1) one year after the first day of the medically necessary leave of absence or (2) the date on which coverage would otherwise terminate under the terms of this Plan.

If a Dependent child is provided health care coverage under the Plan after the child reaches age twenty-six (26), and the coverage for the child is later terminated before the end of the calendar year in which the child turns age thirty (30), the child is ineligible to be covered again for health care benefits unless the child was continuously covered, by other creditable coverage, without a coverage gap of more than sixty-three (63) days.

# BENEFITS AVAILABLE UNDER THE PLAN

## I. Medical and Prescription Drug Benefits

The Board of Trustees has selected **UnitedHealthcare Insurance Co. (UnitedHealthcare) and Neighborhood Health Partnership (Neighborhood Health),** to provide the medical and prescription drug benefits offered by this Plan. **Please check your ID card to see which company provides your coverage. Each company covers participants in different geographical areas.** United and Neighborhood Health have issued health insurance policies to the Plan that provide medical and prescription drug benefits. United and Neighborhood Health each have broad networks of doctors, hospitals and pharmacies that offer covered medical and prescription drug services.

**You can obtain information about your Neighborhood Health plan by calling the number on the back of your ID card; visiting www.mynhp.com; or by calling 1-877-972-8845.**

**You can obtain information about your UnitedHealthcare plan by calling the number on the back of your ID card; visiting www.myuhc.com; or by calling 1-800-357-0978.**

**If you are covered for medical and prescription drug benefits under either UnitedHealthcare or Neighborhood Health policies then you have also been given a Summary of Benefits and Coverage (SBC) and a Schedule of Benefits that list your medical and prescription drug benefits along with your related payment obligations, such as deductibles, co-payments and co-insurance, and rules relating to Network Benefits. Please look at these documents for a description of your covered benefits. Benefit Schedules and related SBCs are important documents that describe your benefits and are incorporated by reference into this Summary Plan Description.**

## *Network Benefits*

Please be sure to check the Benefit Schedules and related SBCs for rules about going to out-of-network providers before you schedule your health care services.

**You can obtain information about your Neighborhood Health provider network by calling the number on the back of your ID card; visiting www.mynhp.com; or by calling 1-877-972-8845.**

**You can obtain information about your UnitedHealthcare provider network by calling the number on the back of your ID card; visiting www.myuhc.com; or by calling 1-800-357-0978.**

## *Your Cost Sharing Obligations*

**Your SBC and your Schedule of Benefits lists what you have to pay for covered services.** Some services require a co-payment, and some services are subject to your deductible and co-insurance. Your SBC and Schedule of Benefits explain in detail how much you will have to pay for different types of services.

When you obtain health care from the doctors, hospitals, pharmacies and other providers in your Provider Network they will submit claims to United or Neighborhood Health on your behalf. You may have to pay your required share of the cost at the time that you receive services.

## *ID Cards*

**You have been issued a UnitedHealthcare ID card or a Neighborhood Health ID card. PLEASE PRESENT YOUR ID CARD WHEN YOU OBTAIN HEALTH CARE SERVICES. You can always contact customer service by using the phone number on the back of your ID card.**

## *Benefits Payable*

**Benefits are payable under the conditions listed in the materials provided by United Healthcare or Neighborhood Health, including the applicable Schedule of Benefits and SBC. You will be required to pay your cost sharing obligations. You may be required to satisfy other conditions as well, such as obtaining a referral from your PCP or obtaining pre-certification or prior authorization for a service.**

## *Prior Authorization*

**There may be services for which you must obtain authorization before you receive the services.** Services for which prior authorization is required are identified in the Schedule of Benefits table within each Covered Health Service category. Please note that prior authorization may be required even if you have a referral from your Primary Physician to seek care from another Network Physician. To obtain prior authorization, call the telephone number for Customer Care on your ID card.

## *Exclusions and Limitations*

**Medical and prescription drug benefits are subject to certain exclusions and limitations, as set forth in the materials provided by UnitedHealthcare or Neighborhood Health, including your Schedule of Benefits and SBC.**

## *Submitting a Claim*

**Claims are normally submitted by your provider.** If your provider does not submit a claim on your behalf then you must submit a claim for payment. Please call Customer Service using the number on your ID card to obtain information about submitting claims.

## *Timely Filing of Out-of-Network Claims*

**If you are covered under either UnitedHealthcare or Neighborhood Health and you receive Covered Health Services from a non-Network provider, then you are responsible for submitting a claim for payment.** You must file the claim in a format that contains all of the information United Healthcare or Neighborhood Health requires. You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide required information within one year of the date of service, Benefits for that health service will be denied or reduced. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends. **Please call the number on your ID card for information relating to filing out of network claims.**

## Benefits required under Federal law

Covered medical benefits will always include all benefits required to be provided under ERISA, the Affordable Care Act, and any other applicable federal law, including the following:

### *Hospital Length of Stay after Childbirth*

This Plan provides maternity benefits in compliance with Federal law. Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean 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 48 hours (or 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 a length of stay not in excess of 48 hours (or 96 hours). The hospital length of stay begins at the time of delivery of the newborn if delivery occurs in the hospital or at the time of admission to the hospital if delivery occurs outside a hospital.

### *Reconstructive Surgery after Mastectomy*

As required by the Women's Health and Cancer Rights Act of 1998 (WHCRA) this Plan provides coverage to any Participant who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, for: (a) All stages of reconstruction of the breast on which the mastectomy was performed; (b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; (c) Prostheses; and (d) Treatment of physical complications of mastectomy, including lymphedema. Coverage will be provided in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and Co-Insurance provisions as set forth herein, and as are consistent with those established for other benefits provided hereunder.

***Parity for Mental Health and Substance Use Disorder Benefits***

This Plan provides mental health benefits in compliance with Federal law. The Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") requires that any group health plan that includes mental health and substance use disorder benefits along with standard medical and surgical coverage must treat them equally in terms of out-of-pocket costs, benefit limits and practices such as prior authorization and utilization review. Your Plan is designed to comply with the requirements of this federal law.

# II. Dental Benefits

The Board of Trustees has selected **UnitedHealthcare Insurance Co. (UnitedHealthcare) and Neighborhood Health Partnership (Neighborhood Health),** to provide the dental benefits offered by this Plan. **Please check your ID card to see which company provides your coverage. Each company covers participants in different geographical areas.** United and Neighborhood Health have issued health insurance policies to the Plan that provide dental benefits.

**You can obtain information about your Neighborhood Health plan by calling the number on the back of your ID card; visiting www.mynhp.com; or by calling 1-877-972-8845.**

**You can obtain information about your UnitedHealthcare plan by calling the number on the back of your ID card; visiting www.myuhc.com; or by calling 1-800-357-0978.**

**If you are covered for dental benefits under either UnitedHealthcare or Neighborhood Health policies then you have also been given a Summary of Benefits and Coverage (SBC) and a Schedule of Benefits that list your dental benefits along with your related payment obligations, such as deductibles, co-payments and co-insurance, and rules relating to Network Benefits. Please look at these documents for a description of your covered benefits. Benefit Schedules and related SBCs are important documents that describe your benefits and are incorporated by reference into this Summary Plan Description.**

## *Network Benefits*

Please be sure to check the Benefit Schedules and related SBCs for rules about going to out-of-network providers before you schedule your health care services.

**You can obtain information about your Neighborhood Health provider network by calling the number on the back of your ID card; visiting www.mynhp.com; or by calling 1-877-972-8845.**

**You can obtain information about your UnitedHealthcare provider network by calling the number on the back of your ID card; visiting www.myuhc.com; or by calling 1-800-357-0978.**

## *Your Cost Sharing Obligations*

**Your SBC and your Schedule of Benefits lists what you have to pay for covered services.** Some services require a co-payment, and some services are subject to your deductible and co-insurance. Your SBC and Schedule of Benefits explain in detail how much you will have to pay for different types of services.

When you obtain health care from the doctors, hospitals, pharmacies and other providers in your Provider Network they will submit claims to United or Neighborhood Health on your behalf. You may have to pay your required share of the cost at the time that you receive services.

### *ID Cards*

**You have been issued a UnitedHealthcare ID card or a Neighborhood Health ID card. PLEASE PRESENT YOUR ID CARD WHEN YOU OBTAIN HEALTH CARE SERVICES. You can always contact customer service by using the phone number on the back of your ID card.**

### *Benefits Payable*

**Benefits are payable under the conditions listed in the materials provided by United Healthcare or Neighborhood Health, including the applicable Schedule of Benefits and SBC. You will be required to pay your cost sharing obligations. You may be required to satisfy other conditions as well, such as obtaining a referral from your PCP or obtaining pre-certification or prior authorization for a service.**

### *Prior Authorization*

**There may be services for which you must obtain authorization before you receive the services.** Services for which prior authorization is required are identified in the Schedule of Benefits table within each Covered Health Service category. Please note that prior authorization may be required even if you have a referral from your Primary Physician to seek care from another Network Physician. To obtain prior authorization, call the telephone number for Customer Care on your ID card.

### *Exclusions and Limitations*

**Dental benefits are subject to certain exclusions and limitations, as set forth in the materials provided by UnitedHealthcare or Neighborhood Health, including your Schedule of Benefits and SBC.**

### *Submitting a Claim*

**Claims are normally submitted by your provider.** If your provider does not submit a claim on your behalf then you must submit a claim for payment. Please call Customer Service using the number on your ID card to obtain information about submitting claims.

### *Timely Filing of Out-of-Network Claims*

**If you are covered under either UnitedHealthcare or Neighborhood Health and you receive Covered Health Services from a non-Network provider, then you are responsible for submitting a claim for payment.** You must file the claim in a format that contains all of the information United Healthcare or Neighborhood Health requires. You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide required information within one year of the date of service, Benefits for that health service will be denied or reduced. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends. **Please call the number on your ID card for information relating to filing out of network claims.**

## III. Vision Benefits

**If you are covered for vision benefits under either UnitedHealthcare or Neighborhood Health policies then you have also been given a Summary of Benefits and Coverage (SBC) and a Schedule of Benefits that list your vision benefits along with your related payment obligations, such as deductibles, co-payments and co-insurance, and rules relating to Network Benefits. Please look at these documents for a description of your covered benefits. Benefit Schedules and related SBCs**

**are important documents that describe your benefits and are incorporated by reference into this Summary Plan Description.**

## *Network Benefits*

Please be sure to check to the Benefit Schedules and related SBCs for rules about going to out-of-network providers before you schedule your health care services.

**You can obtain information about your Neighborhood Health provider network by calling the number on the back of your ID card; visiting www.mynhp.com; or by calling 1-877-972-8845.**

**You can obtain information about your UnitedHealthcare provider network by calling the number on the back of your ID card; visiting www.myuhc.com; or by calling 1-800-357-0978.**

## *Your Cost Sharing Obligations*

**Your SBC and your Schedule of Benefits lists what you have to pay for covered services.** Some services require a co-payment, and some services are subject to your deductible and co-insurance. Your SBC and Schedule of Benefits explain in detail how much you will have to pay for different types of services.

When you obtain health care from the doctors, hospitals, pharmacies and other providers in your Provider Network they will submit claims to United or Neighborhood Health on your behalf. You may have to pay your required share of the cost at the time that you receive services.

## *ID Cards*

**You have been issued a UnitedHealthcare ID card or a Neighborhood Health ID card. PLEASE PRESENT YOUR ID CARD WHEN YOU OBTAIN HEALTH CARE SERVICES. You can always contact customer service by using the phone number on the back of your ID card.**

## *Benefits Payable*

**Benefits are payable under the conditions listed in the materials provided by United Healthcare or Neighborhood Health, including the applicable Schedule of Benefits and SBC. You will be required to pay your cost sharing obligations. You may be required to satisfy other conditions as well, such as obtaining a referral from your PCP or obtaining pre-certification or prior authorization for a service.**

## *Prior Authorization*

**There may be services for which you must obtain authorization before you receive the services.** Services for which prior authorization is required are identified in the Schedule of Benefits table within each Covered Health Service category. Please note that prior authorization may be required even if you have a referral from your Primary Physician to seek care from another Network Physician. To obtain prior authorization, call the telephone number for Customer Care on your ID card.

## *Exclusions and Limitations*

**Vision benefits are subject to certain exclusions and limitations, as set forth in the materials provided by UnitedHealthcare or Neighborhood Health, including your Schedule of Benefits and SBC.**

### *Submitting a Claim*

**Claims are normally submitted by your provider.** If your provider does not submit a claim on your behalf then you must submit a claim for payment. Please call Customer Service using the number on your ID card to obtain information about submitting claims.

### *Timely Filing of Out-of-Network Claims*

**If you are covered under either UnitedHealthcare or Neighborhood Health and you receive Covered Health Services from a non-Network provider, then you are responsible for submitting a claim for payment.** You must file the claim in a format that contains all of the information United Healthcare or Neighborhood Health requires. You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide required information within one year of the date of service, Benefits for that health service will be denied or reduced. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends. **Please call the number on your ID card for information relating to filing out of network claims.**

## IV. Loss of Time Benefits

The Plan offers Loss of Time (short term disability) benefits, as described below. **NEBA** administers loss of time benefits and serves as the Claims Administrator.

Bargaining Unit Employees and Non-Bargaining Unit Employees are eligible for Loss of Time benefits. Retirees and Dependents are not eligible for Loss of Time benefits.

**The Schedule of Benefits for Loss of Time benefits describes available Loss of Time benefits and annual limits on the amount of benefits that you may claim.** Your Schedule of Benefits is important and is attached to and incorporated into this Summary Plan Description.

### *Loss of Time Benefits Payable*

If, as a result of accidental bodily Injury or Illness, you become Totally Disabled, the Plan shall pay, for each day you are so disabled, the applicable amount specified in the Schedule of Benefits, commencing with the applicable day specified in the Schedule of Benefits. Payment of any one period of disability, whether due to one or more causes, shall not exceed the applicable Maximum Benefit Period specified in the Schedule of Benefits. Successive periods of disability not separated by return to or availability for work will be considered one period of disability unless the subsequent disability is due to a cause or causes entirely unrelated to the previous disability.

In order to be eligible for the benefit, you must have been working for or Available for Work with an Employer signatory to a collective bargaining agreement on the day of the accidental bodily Injury or onset of the Illness giving rise to the disability. You shall be presumed to be unavailable for full-time work with a contributing employer if you are employed full-time performing work at the trade for a non-signatory employer.

The Board of Trustees reserves the right to require that you be examined by a Physician selected by the Trustees and to rely on that Physician's findings to determine eligibility for Loss of Time benefits.

### *Submitting a Claim*

You must submit a claim to NEBA to obtain your Loss of Time benefits. Please contact NEBA at 1-800-822-5899 to obtain a copy of the required form to submit your claim. You must send your completed claim form to the claims address listed on the claim form.

**Claims for benefits must be submitted within one year of the date that forms the basis for a claim.**

## V. Health Reimbursement Arrangement

The Board of Trustees has established a Health Reimbursement Arrangement (HRA) to allow covered employees to obtain reimbursement, on a tax favored basis, of allowed qualified medical expenses not otherwise covered under this Plan. Under the Affordable Care Act (ACA) an HRA must be "integrated" with a health care benefit plan that complies with the ACA in order to preserve favorable tax treatment. This HRA is integrated with the health benefits offered under this Plan.

**UnitedHealthcare or Neighborhood Health administer the HRA benefit, and you have been given a Summary of Benefits and Coverage (SBC) and a Schedule of Benefits that list your HRA benefits.**

**If you are in the geographic area of Neighborhood Health, you can find out more about your HRA by calling the number on the back of your ID card; visiting www.mynhp.com; or by calling 1-877-972-8845.**

**If you are in the geographic area of UnitedHealthcare, you can find out more about your HRA by calling the number on the back of your ID card; visiting www.myuhc.com; or by calling 1-800-357-0978.**

# FEDERAL LAW RIGHTS FOR ENROLLMENT AND COVERAGE

## I. Special Enrollment Rights under HIPAA

"Special Enrollment" rights are sometimes allowed under Federal law (HIPAA) to allow employees or dependents to enroll outside of the open enrollment period or after initial eligibility. This section describes when you may have special enrollment rights.

**New Dependents:** If you enroll in the Plan at the time you are first eligible and you remain eligible for coverage you can enroll a new dependent as a result of marriage, birth, adoption, placement for adoption, or legal guardianship by submitting a request for enrollment within 31 days after the marriage, birth, adoption, placement for adoption or legal guardianship.

Limited "Special Enrollment" rights are also allowed under Federal law (HIPAA) if you decline or waive enrollment in the Plan and do not have other health insurance. Under these special enrollment rights you may request enrollment for yourself and/or your dependents outside of open enrollment if:

- You have a new dependent as a result of marriage, birth, adoption, placement for adoption, or legal guardianship and
- You request enrollment within 31 days after the marriage, birth, adoption, placement for adoption or legal guardianship.

**Loss of Other Coverage:** If you decline or waive enrollment in the Plan because you have other health insurance coverage, you may be allowed "special enrollment" rights in the future if:

- You are covered under another group health plan or health insurance program at the time you waive coverage under the Plan;
- You lose eligibility for the health care coverage you had at the time of waiver, or the employer sponsoring the other coverage stops contributing towards such other coverage; and
- You make application for enrollment in the Plan within 30 days after your other coverage ends.

**Loss of Medicaid or State Child Health Insurance Program:** There are special rules for employees and dependents of employees who are eligible for Medicaid or a State Child Health Insurance Program. If an employee (or eligible dependent of such employee) experiences a loss of eligibility for Medicaid or a State Child Health Insurance Program, they have a Special Enrollment right to request enrollment in the Plan provided a request for enrollment is made within 60 days after the loss of eligibility.

**Premium Assistance:** If an employee (or eligible dependent of such employee) is determined to be eligible for premium assistance by Medicaid or a State Child Health Insurance Program (including under any waiver or demonstration project conducted under or in relation to such a program), such person has a Special Enrollment right to request enrollment in the Plan provided a request for enrollment is made within 60 days of the determination of assistance.

Employees who enroll in the Plan under these special circumstances will be offered the same benefit packages and payment options as those offered to similarly situated employees who enroll when first eligible.

## II. Qualified Medical Child Support Orders

Federal law requires that this Plan extend health care coverage directly to the children of a parent-employee who is divorced, separated, or never married when ordered to do so by state authorities. Generally, a State court or agency may require an ERISA-covered health plan to provide health benefits coverage to children by issuing a medical child support order. The group health plan must determine whether the medical child support order is "Qualified." Such an order is referred to as a Qualified Medical Child Support Order (QMCSO). Any judgment, decree, or order that is issued by a court of competent jurisdiction or an administrative agency authorized to issue child support orders under State law (such as a State child support enforcement agency) that provides for medical support of a child is a medical child support order. In addition, a State child support enforcement agency may obtain group health coverage for a child by issuing a National Medical Support Notice that the group health plan determines to be qualified. A medical child support order must contain the following information in order to be Qualified:

- The name and last known mailing address of the participant and each alternate recipient. The order may substitute the name and mailing address of a State or local official for the mailing address of any alternate recipient;
- A reasonable description of the type of health coverage to be provided to each alternate recipient (or the manner in which such coverage is to be determined) ; and
- The period to which the order applies.

All requests for enrollment and/or claims for benefits pursuant to a medical child support order shall be submitted, in writing, to the Third Party Administrator along with a copy of the medical child support order. The Third Party Administrator can be reached at: National Employee Benefits Administrators, Inc., 2010 N.W. 150th Avenue, Suite 100, Pembroke Pines, Florida 33028, 1-800-842-5899.

Upon receipt of a medical child support order the Third Party Administrator shall notify the Employee and each Alternate Recipient named in the order that the medical child support order was received and shall provide each with a written copy of the procedures for determining whether the order is Qualified. Notices shall be sent to the addresses shown in the medical child support order. Alternate Recipients may designate an attorney or other representative to receive copies of notices and communications sent to them relating to a medical child support order by submitting a written and signed authorization to the Third Party Administrator.

The Board of Trustees shall consult with legal counsel and shall determine whether an order is a Qualified Medical Child Support Order no later than the date of the Board of Trustees' meeting that

immediately follows the Plan's receipt of the medical child support order, unless it is submitted within 30 days preceding the date of such meeting. If a medical child support order is submitted less than 30 days before the next meeting, the Board of Trustees shall determine whether it is a QMCSO no later than the date of the second meeting following the Plan's receipt of the order. If special circumstances require a further extension of time, the Board of Trustees shall make the determination not later than the date of the third meeting following the Plan's receipt of the order.

The Trustees will provide notice of their decision to the Employee and to the Alternate Recipient as soon as possible, but not later than 5 days after the determination is made. The Trustees will notify the Employee and each Alternate Recipient of a denial of benefits based on a determination that a medical child support order is not qualified following the procedures established under this Plan for notification of benefit claim denials. The decision can be appealed by filing a notice of appeal within sixty (60) days after receipt of the Trustees' decision.

If the Third Party Administrator receives an appropriately completed National Medical Support Notice that meets the requirements for a QMCSO set forth above, the Notice shall be deemed to be a QMCSO.

Pending a decision by the Board of Trustees as to whether a medical child support order is a QMCSO any amount which would be payable for benefits on behalf of such Alternate Recipient may be withheld.

## III. Continuation Coverage under COBRA

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Covered Employees and/or their Dependents may be entitled to temporarily extend their coverage under this Plan by electing COBRA continuation coverage after their eligibility for coverage under the Plan has terminated.

The following sets forth important information about your right to COBRA continuation coverage. It explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

### *What is COBRA Continuation Coverage?*

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

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

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

## *When is COBRA Coverage Available?*

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Third Party Administrator has been notified that a qualifying event has occurred. The employer must notify the Third Party Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

## *You Must Give Notice of Some Qualifying Events*

**For the other qualifying events (divorce or legal separation of the employee and spouse, a dependent child's losing eligibility for coverage as a dependent child, or the occurrence of an event that qualifies as a Second Qualifying Event that entitles you to an extension of your COBRA coverage), you must notify the Third Party Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Third Party Administrator at**

**National Employee Benefits Administrators, Inc.**
2010 N.W. 150th Avenue, Suite 100
Pembroke Pines, Florida 33028
1-800-842-5899

## *How is COBRA Coverage Provided?*

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended.

## *Disability extension of 18-month period of continuation coverage*

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Third Party Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

## *Second qualifying event extension of 18-month period of continuation coverage*

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

## *Are there other coverage options besides COBRA Continuation Coverage?*

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

## *If You Have Questions*

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

## *Keep Your Plan Informed of Address Changes*

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

## *Plan Contact Information*

**Sheetmetal Workers Local Union No. 32 Health And Welfare Benefit Plan**
c/o National Employee Benefits Administrators, Inc.
2010 N.W. 150th Avenue, Suite 100
Pembroke Pines, Florida 33028
1-800-842-5899

# IV. Continuation Coverage under USERRA

The right to continuation coverage when you leave work to perform military service is provided under a federal law called the Uniformed Services Employment and Re-employment Rights Act of 1994 ("USERRA"). If you leave your employment to perform services in the uniformed services you may elect to continue coverage under the Plan for yourself and your dependents up to a maximum period of time that is the lesser of:

(a) the 24-month period beginning on the date on which the absence for the purpose of performing military service begins; or

(b) the period beginning on the date upon which the absence for the purpose of performing military service begins, and ending on the day after the date on which the Covered Employee fails to apply for or return to a position of employment, as defined in USERRA.

If your service in the uniformed services continues for fewer than 31 days you will not be required to pay more than any regular employee share for continuing health plan coverage.

If your service in the uniformed services continues for more than 31 days and you elect continuation coverage you may be required to pay no more than 102 percent of the full premium under the Plan, representing the employer's share plus the employee's share plus 2% for administrative costs.

If you enter military service lasting more than 31 days; your eligibility is based on your reserve account; you elect continuation coverage; and you have a positive balance in your reserve account at the time you leave employment, you may either:

(a) use your reserve account balance instead of paying for continuation coverage, with the opportunity to continue coverage by paying no more than 102% of the full premium under the Plan if your reserve account balance is depleted; or

(b) pay for continuation coverage as provided above in order to maintain your reserve account balance intact as of the beginning date of your military service.

If you leave employment for military service without giving advance notice or with notice but without electing continuation coverage then your coverage may be terminated under the terms of the Plan. Depending on the circumstances you may be eligible for retroactive reinstatement of coverage. You may also lose coverage if you fail to make required payments.

If your coverage is terminated as a result of your service in the uniformed services your coverage under the Plan will be re-instated immediately upon re-employment after military service. You will not be subject to any exclusions or waiting periods if exclusions or waiting periods would not have been imposed if your coverage had not been terminated as a result of military service, unless you have an injury or illness determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

If your eligibility for coverage is based on maintaining required numbers of hours or weeks in a reserve account your coverage will be re-instated immediately, even if you do not have sufficient hours or

weeks in your reserve account to establish coverage. The Plan may require that you pay the cost of coverage until the time that your reserve account contains sufficient hours or weeks to sustain coverage.

## V. FMLA Authorized Leave

Employees receiving benefits under this Plan may be eligible to take Authorized Leave under the Family and Medical Leave Act ("FMLA") if an Employee is granted Authorized Leave under FMLA by his or her Employer.

***An Employee's Employer has all responsibilities and obligations under FMLA to determine whether and when an Employee is eligible for Authorized Leave under FMLA.*** The Trustees have no responsibilities or obligations relating to such determination, except to the extent that the Plan is the Employer of any Employees receiving benefits.

An Employer who grants Authorized Leave under FMLA to an Employee is required to notify the Third Party Administrator at the time the Authorized Leave period begins and provide all relevant information regarding the Employee's Authorized Leave.

### *FMLA Authorized Leave*

Pursuant to FMLA, Authorized Leave may be granted to an Employee by an Employer for a period of up to 12 workweeks during a 12 month period, or, in the case of Authorized Leave to care for a servicemember, up to 26 workweeks during a 12 month period.

Pursuant to FMLA, Authorized Leave means leave from employment granted for the following specified reasons:

(a) For the birth of an Employee's child, and to care for such child;

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

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

(d) Because of a serious health condition that makes the Employee unable to perform the function of the Employee's job;

(e) Because of a qualifying exigency arising out of the fact that an Employee's spouse, child or parent is on active duty in the Armed Forces in support of a contingency operation; or

(f) To care for the Employee's spouse, child, parent or next of kin who is a covered service member, as defined in the Family and Medical Leave Act.

### *Employer Obligations during FMLA Authorized Leave*

Pursuant to FMLA, an Employer who grants FMLA Authorized Leave to an Employee is required to maintain group health insurance coverage for the Employee during the period of Authorized Leave on the same conditions as if the Employee had been continuously employed. An Employer must therefore continue to make contributions to the Plan in the amount and manner as would otherwise be required if the Employee was not on Authorized Leave.

An Employer is required to maintain group coverage for an Employee on Authorized FMLA Leave until:

(a) the Employee's FMLA Leave entitlement is exhausted;

(b) the Employer can show that the Employee would have been laid off and the employment relationship terminated; or

(c) the Employee provides unequivocal notice of intent not to return to work.

***Employee Rights and Obligations during FMLA Authorized Leave***

An Employee may not be required to use any hours in his reserve account during a period of FMLA Authorized Leave, and may not be required to pay a greater premium than the Employee would have been required to pay if the Employee had been continuously employed.

An Employee remains obligated to make payment of any co-payments or other financial obligations which are due to be paid by the Employee in order to maintain continuing coverage during the period of Authorized Leave.

***Failure by Employee to Make Required Contributions***

The Plan will not terminate an Employee's eligibility for failure to make required contributions during a period of FMLA leave until and unless the Plan receives certification from the Employer that notice was properly given to the Employee that coverage would be terminated if payment was not received, as required under 29 CFR §825.212(a)(1). Nothing in this section shall be construed to prohibit an Employer from making payment of any co-contributions on behalf of an Employee.

If an Employee's eligibility for coverage during Authorized FMLA Leave is terminated due to the Employee's failure to make required contributions, then the Employer's contribution obligation under this Article may be suspended for the duration of the Employee's Authorized Leave.

***Reinstatement after FMLA Authorized Leave***

If an Employee's coverage during FMLA Authorized Leave lapses for failure to make required contributions, and the Employee returns to employment after FMLA Authorized Leave, the Employee's eligibility for coverage shall be restored upon re-employment under the same conditions as if the Employee had been continuously employed, and without being required to meet any qualification requirements, including pre-existing condition waiting periods.

If an Employee on Authorized FMLA Leave chooses not to retain coverage under the Plan during the period of leave, and returns to employment after FMLA Authorized Leave, the Employee is entitled to be reinstated upon re-employment on the same terms as prior to taking the leave, and without being required to meet any qualification requirements, including pre-existing condition waiting periods.

***FMLA Authorized Leave and COBRA Continuation Coverage***

Authorized Leave granted to an Employee by an Employer pursuant to FMLA is not a Qualifying Event as described in Article 14 Eligibility for Continuation Coverage. If an Employee fails to return to work at the end of a period of Authorized Leave, however, such failure to return to work terminates an Employer's obligation to continue coverage, and may constitute a Qualifying Event as that term is defined in Article 14 Eligibility for Continuation Coverage.

# CLAIMS PROCEDURES

The Plan is required by law to follow certain procedures in processing, reviewing and paying claims. The following procedures apply for the filing and processing of benefit claims; the notification of benefit determinations; and the appeal of adverse benefit determinations.

**ALL BENEFITS UNDER THIS PLAN ARE PROVIDED THROUGH FULLY INSURED POLICIES ISSUED BY INSURANCE COMPANIES. Therefore, the insurance company that issued each policy is the Claims Administrator for benefits provided under each policy and has full discretion and authority in connection with processing, reviewing and paying claims.**

**Health and prescription drug benefits are provided through policies issued by UnitedHealthcare Insurance Co. (UnitedHealthcare) and Neighborhood Health Partnership (Neighborhood Health),**

**which act as Claims Administrators for these benefits. Please see information earlier in this document under the heading "Benefits Available under the Plan, Medical and Prescription Drug Benefits" for additional information about submitting claims for benefits.**

**Dental benefits are provided through a policy issued by Solstice Benefits, which acts as Claims Administrator for these benefits. Please see information earlier in this document under the heading "Benefits Available under the Plan, Dental Benefits" for additional information about submitting claims for benefits.**

**Life insurance benefits are provided through a policy issued by UnitedHealthcare Insurance, which acts as Claims Administrator for these benefits. Please see information earlier in this document under the heading "Benefits Available under the Plan, Life Insurance Benefits" for additional information about submitting claims for benefits.**

**ALL INSURANCE COMPANIES PROVIDING BENEFITS UNDER THE PLAN ARE REQUIRED TO FOLLOW THE FOLLOWING CLAIMS PROCEDURES AND RULES REQUIRED UNDER FEDERAL LAW.**

## I. Time for Filing Claims

Either you or your health care provider must submit your claims for benefits to the appropriate Claims Administrator for each type of claim. **Please note and follow any time limits for filing claims or appealing adverse benefit determinations. Time limits are set forth in materials provided by the insurance company that provides each type of benefit.**

## II. Claims Determination Procedures

Once a benefit claim is filed the appropriate Claims Administrator follows set procedures to evaluate the claim and determine the benefits available under the terms of the Plan. The time periods for benefit claim determinations are different depending on the type of claim, as described below. All benefit claim determinations are made following governing plan documents and will be applied consistently with respect to similarly situated claimants.

### A. Time Periods for Claims Determinations

***All benefit claim determinations will be made within the time periods specified herein.*** The applicable time period begins at the time you file a claim under the procedures provided, whether or not you have provided all of the information necessary to make a benefit determination.

If you fail to submit information necessary to decide a claim, however, the Claims Administrator will need more time before making a determination. If the time period for making a determination is extended for any of the reasons described below, then the period for making the benefit determination is frozen from the date on which you are notified of the need for an extension of time until the date on which you respond to the request for additional information.

### B. Time Periods for Determinations of Medical, Prescription Drug, Dental and Vision Claims

The Claims Administrator will process claims for Medical, Prescription Drug, Dental, or Vision benefits upon receipt of each claim and will subsequently notify you of the benefit determination. Claims will be processed based on procedures and within the time period allowed for each type of claim, as follows:

#### *1. Urgent Care Claims*

An "Urgent Care Claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations—(A) could seriously

jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (B) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The determination of whether a claim is an Urgent Care Claim is to be made by a person acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, except that any claim that a physician with knowledge of the claimant's medical condition determines is an Urgent Care Claim shall be treated as an Urgent Care Claim, and the Plan shall defer to any determination by the attending provider that a claim is an Urgent Care Claim.

If you submit an Urgent Care Claim then the Claims Administrator will notify you of the Plan's benefit determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim, unless you failed to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.

If you failed to provide sufficient information, the Claims Administrator will notify you as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Following such notification the Claims Administrator will notify you of the benefit determination as soon as possible, but in no case later than 48 hours after (i) the Plan receives the specified information, or (ii) the end of the period afforded to provide the specified additional information, whichever is earlier.

### *2. Concurrent Care Claims*

A Concurrent Care Claim is a claim for benefits for an approved ongoing course of treatment to be provided over a period of time or number of treatments.

It will be considered as an "adverse benefit determination" if, after approval of a course of treatment, there is a reduction or termination of the benefits (other than by plan amendment or termination) before the end of the approved time period or number of treatments. The Claims Administrator shall notify you of such a change in benefits at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review before the benefit is reduced or terminated.

A request to extend an approved ongoing course of treatment beyond the approved time period or number of treatments may also be an Urgent Care Claim depending on the circumstances. An Urgent Care Claim for extension of an approved ongoing course of treatment shall be decided as soon as possible, taking into account the medical exigencies. If such a claim is made to the Claims Administrator at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, the Claims Administrator shall notify the Participant of the benefit determination within 24 hours after receipt of the claim.

### *3. Pre-Service Claims*

A "Pre-Service Claim" is any claim for a benefit that requires, in whole or in part, approval of the benefit in advance of obtaining medical care. ***Some benefits under the Plan require pre-approval before the benefit is provided, and you must be sure to submit a Pre-Service Claim in order to obtain coverage for such benefits.***

The Claims Administrator will notify you that your Pre-Service Claim has been approved or denied within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan.

This time period may be extended once by the Claims Administrator, for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan, and notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision.

If the Claims Administrator determines that an extension of time is necessary because you failed to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you will have at least 45 days from receipt of the notice to provide the specified information.

If you or your authorized representative fail to follow the Plan's procedures for filing a Pre-Service Claim, then you or your authorized representative will be notified of the failure and of the proper procedures to be followed, provided that the failure to follow procedures is a communication as described in 29 C.F.R. §2560.503-1(c) (1)(ii). This notification shall be made as soon as possible, but no later than 24 hours following a failure to properly file a Pre-Service Claim involving Urgent Care, or 5 days following a failure to properly file any other type of Pre-Service Claim. This notification may be made orally, unless you or your authorized representative requests written notification.

### *4. Post-Service Claims*

A "Post-Service Claim" is a claim for a benefit that is filed after the services have been provided. The Claims Administrator shall notify you of an adverse benefit determination of a Post-Service Claim within a reasonable period of time, but not later than 30 days after receipt of the claim.

This period may be extended one time by the Claims Administrator, for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan, and notifies you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision.

If the Claims Administrator determines that an extension of time is necessary because you failed to submit the information necessary to decide the claim, then the notice of extension shall specifically describe the required information, and you will have at least 45 days from receipt of the notice within which to provide the specified information.

## C. Time Period for Determination of Loss of Time Claims

The Claims Administrator will process a claim for Loss of Time benefits and notify you of the determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan.

This period may be extended by the Claims Administrator, for up to 30 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan, and notifies you, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision.

If, prior to the end of the first 30-day extension period, the Claims Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Claims Administrator notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Claims Administrator expects to render a decision.

In the case of any extension under this paragraph, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and you shall have at least 45 days within which to provide the specified information.

### D. Time Period for Determination of Claims relating to HRA Benefits

After you submit a claim for Life Insurance Benefits, the Claims Administrator will process the claim and notify you of its determination within a reasonable period of time not exceeding 90 days. The Claims Administrator may extend the 90-day limitation if special circumstances so require.

## III. Adverse Benefit Determinations

***An "adverse benefit determination" is any decision on a claim that is a denial, reduction, or termination of benefits.*** More specifically, the term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's eligibility to participate in the Plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. A rescission of coverage is also an 'adverse benefit determination" for this purpose, whether or not there is an adverse effect on any particular benefit at the time of the rescission.

### A. Time Period for Notification of Adverse Benefit Determinations

Except as otherwise described above, if a claim is wholly or partially denied, the Claims Administrator shall notify you of the adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the Claims Administrator, unless the Claims Administrator determines that special circumstances require an extension of time for processing the claim.

If the Claims Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to you prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Claims Administrator expects to render the benefit determination.

### B. Manner and Content of Notification of Adverse Benefit Determinations

Except as otherwise described below, the Claims Administrator shall provide written or electronic notification of any adverse benefit determination. The notice shall be culturally and linguistically appropriate.

In the case of an adverse benefit determination on an Urgent Care Claim, notification may be given orally within the time frame described above, provided that a written or electronic notification is furnished not later than 3 days following the date of oral notification.

The notification of an adverse benefit determination shall set forth the following information:

(1) Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount, the diagnosis code, the treatment code and the meanings of any such codes.

(2) The specific reason or reasons for the adverse determination, including the denial code and its meaning and a description of the standard that was used in denying the claim;

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

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

(5) A description of the Plan's review procedures and the time limits applicable to such procedures, including a description of available internal appeals and external review processes and information regarding how to initiate an appeal;

(6) A statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;

(7) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request;

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

(9) If the adverse benefit determination relates to a claim involving urgent care, a description of the expedited review process applicable to such claims; and

(10) Contact information for any office of health insurance consumer assistance available to assist individuals with the internal claims and appeals process and applicable external review processes.

(11) In the case of an adverse benefit determination concerning a claim involving urgent care—

i. A description of the expedited review process applicable to such claims.

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

(12) In the case of an adverse benefit determination with respect to Loss of Time benefits—

i. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(i) The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

(ii) The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(iii) A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration;

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

iii. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist; and

iv. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to the definition in these claims procedures.

# IV. Appeals of Adverse Benefit Determinations

## A. Right to Appeal

You have a right to appeal an adverse benefit determination relating to any claim for benefits under this Plan to an appropriate named fiduciary of the Plan for a full and fair review of the claim and the adverse benefit determination.

The Claims Administrator for each type of benefit is authorized to administer and determine appeals. The Claims Administrator may use alternate procedures than those described here as long as alternate procedures meet or exceed the standards set forth here.

## B. Time Period for Appeal

Unless otherwise provided herein, you will have *at least 60 days* following receipt of an adverse benefit determination to appeal the determination. Appeals of adverse benefit determinations must be brought by you or by your authorized representative. The Plan will provide continued coverage pending the outcome of an appeal and will comply with required notice provisions before reducing or terminating an ongoing course of treatment.

*If you are covered for medical and prescription drug benefits under either UnitedHealthcare or Neighborhood Health you must submit your first appeal request within 180 days after you receive the denial of a pre-service request for Benefits or a claim denial.*

## C. Opportunity to Review and Submit Material Relevant to Your Claim

You will have the opportunity to submit written comments, documents, records and other information relating to the claim for benefits. The Claims Administrator will provide, free of charge and upon request, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits. The Claims Administrator will also provide, free of charge, any new or additional evidence considered, relied upon, or generated by the Plan or at the direction of the Plan in connection with your claim. Any such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided, so that you have a reasonable opportunity to respond prior to that date.

The Claims Administrator will not issue a final internal adverse benefit determination based on a new or additional rationale before first providing the rationale to you, free of charge, as soon as possible, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided, so that you have a reasonable opportunity to respond prior to that date.

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

The review shall take into account all comments, documents, records, and other information that you submit relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Trustees expect that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly the Claims Administrator will not make any personnel decisions, including hiring, compensation, termination, promotion or other similar actions, based upon the likelihood that the persons involved in the claims review procedure will support the denial of benefits.

## D. Additional Time Period and Procedures for Appeals of Claims for Medical, Prescription Drug, Dental and Vision Benefits

*Appeals of adverse benefit determinations of claims for Medical, Prescription Drug, Dental and Vision benefits must be submitted in writing within 180 days of your receipt of an adverse benefit determination.*

The appropriate Claims Administrator will consider and decide all appeals of adverse benefit determinations for claims for Medical, Prescription Drug, Dental and vision benefits taking into account all comments, documents, records and other information submitted by the claimant relating to the claims, without regard to whether such information was submitted or considered in the initial benefit determination. The Claims Administrator will not afford deference to the initial adverse benefit determination, and the review will be conducted by a fiduciary who did not make the initial adverse benefit determination and who is not a subordinate of the person who did.

If an adverse benefit determination is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The professional so consulted will not be a person who was consulted in connection with the adverse benefit determination that is the subject of the appeal, and will not be a subordinate of any expert consulted in connection with the adverse determination under appeal.

If medical or vocational experts were consulted on behalf of the Plan in connection with an adverse benefit determination, such experts will be identified, whether or not the advice obtained was relied upon in making the benefit determination.

Appeals of adverse benefit determinations of claims for Medical, Prescription Drug, or Dental benefits involving urgent care will include an expedited review process. Under the expedited review process a request for an expedited appeal may be submitted orally or in writing by the claimant, and all necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

## E. Time for Determination and Notification of Decision after Appeal

All appeals of adverse benefit claim determinations will be made within 60 days, except as the time periods described below. The applicable time period begins at the time a request for an appeal is received by the Plan in accordance with the procedures for filing appeals, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. *If you fail to submit information necessary to decide a claim, and an applicable time period is extended as permitted herein, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.*

If an extension of time for review is required because of special circumstances, the Claims Administrator shall provide written notice of the extension, prior to the commencement of the extension, describing the special circumstances and the date as of which the benefit determination will be made.

The Claims Administrator shall notify you of a benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

## F. Time for Determination and Notification of Decision after Appeal of Certain Types of Health Care Claims

### *1. Urgent Care Claims*

If you appealed an adverse benefit determination of an Urgent Care Claim the Claims Administrator will notify you of the Plan's decision on appeal as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination.

### *2. Pre-Service Claims*

If you appealed an adverse benefit determination of a Pre-Service Claim the Claims Administrator will notify you of the Plan's decision on appeal within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the claimant's request for review of an adverse benefit determination.

### *3. Disability and Post-Service Claims*

Except as otherwise provided herein for certain types of health care claims, if the Board of Trustees is considering the appeal the Board shall make a benefit determination no later than the date of the Board of Trustees' meeting that immediately follows the Plan's receipt of your request for review, unless the request for review is filed within 30 days preceding the date of such meeting. If your request for review is filed less than 30 days before the next meeting, the Board shall make a determination no later than the date of the second meeting following the Plan's receipt of your request for review. If special circumstances require a further extension of time for processing, a benefit determination shall be rendered not later than the date of the third meeting following the Plan's receipt of your request for review. If an extension of time for review is required because of special circumstances, the Plan Administrator shall provide you written notice of the extension, prior to the commencement of the extension, describing the special circumstances and the date as of which the benefit determination will

be made. The Plan Administrator shall notify you of a benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

## G. Manner and Content of Notification of Decision after Appeal

The Claims Administrator shall provide written or electronic notification to the claimant of the decision on a claim after appeal and review.

In the case of an adverse benefit determination, the notification shall set forth the following information—

(1) Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount, the diagnosis code, the treatment code and the meanings of any such codes.

(2) The specific reason or reasons for the adverse determination, including the denial code and its meaning, a description of the standard that was used in denying the claim, and a discussion of the reasons supporting the decision;

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

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

(5) A description of the Plan's review procedures and the time limits applicable to such procedures, including a description of available internal appeals and external review processes and information regarding how to initiate an appeal;

(6) A statement of the claimant's right to bring an action under section 502(a) of ERISA, including a description of any applicable contractual limitations period that applies to the claimant’s right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim;

(7) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

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

(9) In the case of an adverse benefit decision with respect to Loss of Time benefits—

a. Any applicable contractual limitations period that applies to the claimant's right to bring an action under section 502(a) of ERISA, including the calendar date on which the contractual limitations period expires for the claim.

b. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

i. The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

ii. The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit

determination, without regard to whether the advice was relied upon in making the benefit determination; and

iii. A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration;

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

d. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist.

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

(11) Contact information for any office of health insurance consumer assistance available to assist individuals with the internal claims and appeals process and applicable external review processes.

## H. External Review Procedures

If you appealed an adverse benefit determination and your appeal was denied, you may request an external review of the Plan's decision by an Independent Review Organization ("IRO"). The following describes your rights and responsibilities in connection with an external review of the Plan's adverse benefit determination.

Depending on the circumstances you may request either a Standard external review or an Expedited external review. An Expedited external review is available when the time frame to complete a standard external review would seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function, or if the claim involves care related to emergency services received by the claimant and the claimant has not been discharged from a facility.

You must request an external review of a final adverse benefit determination under procedures established by the network provider through which your benefits were provided. If you receive benefits through a fully insured policy provided by an insurance company then you must request an external review under procedures established by the insurance company. Please consult the information provided to you by the insurance company to obtain information on how to file a request for an external review of your denied claim.

External review procedures are provided through the insurance company that provides your medical and prescription drug benefits, either UnitedHealthcare or Neighborhood Health, and must comply with the federal law guidelines described below.

### *1. Standard External Review*

(a) ***Request for external review.*** You may file a request for an external review within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse

benefit determination. If that date falls on a weekend or holiday you have until the next business day.

(b) ***Preliminary review.*** Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:

1. The claimant is or was covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care service was provided;
2. The adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the eligibility requirements under the terms of the Plan;
3. The claimant has exhausted the plan's internal appeals process, unless the claimant is not required to do so under the applicable regulations; and
4. The claimant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Plan must issue a written notification to the claimant. If the request is complete but not eligible for external review, such written notification must include the reasons the claim is ineligible and contact information for the DOL's Employee Benefits Security Administration. If the request is not complete, the written notification must describe the information needed to complete the request, and the claimant must be permitted to perfect the request within the four-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

(c) ***Referral to Independent Review Organization (IRO).*** If the request for review is complete and is eligible for external review then UnitedHealthcare or Neighborhood Health will assign an Independent Review Organization (IRO) that is accredited under the appropriate regulations and federal guidance to conduct the external review. In order to prevent against bias and ensure independence, the Plan or the network providers have established or will establish contracts with at least three (3) IROs for assignments and will rotate claims assignments among them (or will incorporate other independent, unbiased methods for selection of IROs, such as random selection). The IROs are prohibited from receiving any financial incentives based on the likelihood that the IRO will support the denial of benefits.

(d) ***Procedures for IRO External Review:*** The assigned IRO will conduct the external review following applicable federal guidelines, as described in its contract, and using legal experts as necessary. The IRO assigned to review the claim will let the claimant know in writing that it will be conducting the external review and will give the claimant a notice stating that the claimant may submit, in writing, within 10 business days following the date of receipt of the notice, additional information that the IRO must consider when conducting the external review. The IRO may also consider information provided by the claimant after the 10 day window but is not required to do so. Upon receipt of any information from the claimant the IRO will promptly forward the information to the Plan within one business day, and the Plan may reconsider it decision to deny the claim. If the Plan were to reconsider its decision and allow the claim then the external review will be terminated upon receipt of notice of the Plan's decision.

The Plan will provide to the assigned IRO the documents and any information considered in making the adverse benefit determination within 5 business days after the date of assignment.

The IRO will review all of the information and documents timely received, and will review the claim without deferring to any decisions or conclusions reach during the plan's appeal process. The IRO may also consider, if the IRO thinks it is appropriate, the following:

1. The claimant's medical records;
2. The attending health care professional's recommendation;
3. Reports from appropriate health care professionals and other documents submitted by the Plan, claimant or the claimant's treating provider;
4. The terms of the plan to ensure that the IRO's decision is not contrary to them, as long as the terms are consistent with applicable law;
5. Appropriate practice guidelines, which must include applicable evidence based standards and may include any other practice guidelines developed by the federal government or national or professional medical societies, boards or associations;
6. Any applicable clinical review criteria developed and used by the Plan; and
7. The opinion of the IRO's clinical reviewer after considering the information described in the notice, as long as the documents are available and the clinical review considers them appropriate.

(e) ***Written notice:*** The assigned IRO will provide written notice of the final external review decision to the Plan and to the claimant within 45 days after the IRO receives the request for the external review. The IRO's decision notice will include the following:

1. A general description of the reason for the request for external review, the reason for the previous denial and information sufficient to identify the claim, the diagnosis code, treatment code, and explanations of the codes;
2. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
3. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards considered in reaching its decision;
4. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standard that were relied on in making its decision;
5. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the group health plan or to the claimant;
6. A statement that judicial review may be available to the claimant; and
7. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the new federal health care reform law.

(f) ***Reversal of plan's decision.*** The IRO could determine after external review that the adverse benefit determination should be reversed. Upon receipt of a notice of a final external review decision that reverses the adverse benefit determination or final internal adverse benefit determination, the Plan is required to immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

(g) ***Records to be maintained:*** After a final external review decision the IRO must maintain record of all claims and notices associated with the external review process for six years. The IRO must make such records available for examination by the claimant, the Plan, or state or federal oversight agencies upon request, unless prohibited by law.

## *2. Expedited External Review*

**(a)** ***Request for expedited external review.*** You may make a request for an expedited external review when you receive:

1. An adverse benefit determination that involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of

the claimant or would jeopardize the claimant's ability to regain maximum function, and the claimant has filed a request for an expedited internal appeal; or

2. A final internal adverse benefit determination and the claimant has a medical condition where the time frame for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

**(b)** ***Preliminary Review.*** Upon receipt of a request for an expedited external review the Claims Administrator will immediately determine whether the request meets the standards described above for standard external review. The plan will send a notice regarding its preliminary review as soon as possible notifying the claimant of its eligibility determination.

**(c)** ***Referral to Independent Review Organization (IRO).*** Upon determination that a request is eligible for external review the Claims Administrator will assign an Independent Review Organization following the procedures described above for standard external reviews. The Plan will provide all necessary documents and information considered in making the adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO will consider the documents and information provided under the standards and procedures described above for standard external reviews. In reaching a decision the assigned IRO will review the claim *de novo* and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

**(d)** ***Notice of final external review decision.*** The IRO will provide notice of the final external review decision following the requirements and procedures described above for standard external review decisions as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice the assigned IRO must provide written confirmation of the decision to the claimant and the Plan.

# OTHER IMPORTANT INFORMATION ABOUT YOUR BENEFITS

## I. Circumstances That Could Affect Your Receipt of Benefits

***Fraud or Misrepresentation:*** The Plan or the appropriate Claims Administrator shall have the right to recover whatever benefits are paid on behalf of any person when the basis of such claim is misrepresented or fraudulently presented, whether by a Participant or by any medical service provider(s). If fraud or misrepresentation is established the Plan or the appropriate Claims Administrator shall have the right to recover all benefits paid. Such recovery may also include medical investigation charges, auditors' fees and attorney fees, as necessary. **Each insurance company providing benefits through this Plan under insurance policies will have its own enforceable rights to recover benefits obtained through fraud or misrepresentation, as set forth in each policy and other materials provided by each insurance company. Please consult the terms of each insurance policy for important information about each insurance company's rights.**

***Coordination of Benefits:*** If you are enrolled in more than one health care benefit plan, one is held as primary and the others are secondary or tertiary. You are required to provide the insurance company that provides your benefits, either UnitedHealthcare or Neighborhood Health, updated information regarding

your other coverage as requested. **The rules governing Coordination of Benefits are set forth in the materials provided by UnitedHealthcare or Neighborhood Health. Call the number on the back of your ID card for more information on coordination of benefits with other healthcare plans.**

***Reimbursement and Subrogation:*** The following conditions apply if a Participant incurs a covered expense for which, in the opinion of the Plan or the appropriate Claims Administrator, another party may be responsible or for which the Participant may receive payment.

- *Subrogation:* The Plan or the appropriate Claims Administrator shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the Plan. A Participant or his or her representative shall execute such documents as may be required to secure the Plan's subrogation rights.
- *Right of Reimbursement:* The Plan or the appropriate Claims Administrator is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted above, but only to the extent of the benefits provided under the Plan.
- **Each insurance company providing benefits through this Plan under insurance policies will have its own enforceable rights in connection with subrogation and reimbursement, as set forth in each policy and other materials provided by each insurance company. Please consult the terms of each insurance policy for important information about each insurance company's rights.**

***Right to Recover Excess Payments:*** Whenever payments have been made in excess of the maximum amount of payment allowed under the Plan, the Plan or the appropriate Claims Administrator shall have the right to recover such payments, to the extent of such excess. **Each insurance company providing benefits through this Plan under insurance policies will have its own enforceable rights to recover excess payments, as set forth in each policy and other materials provided by each insurance company. Please consult the terms of each insurance policy for important information about each insurance company's rights.**

## II. Other Important Information

***Assignment of Claims:*** Each insurance company providing benefits through this Plan under insurance policies will have enforceable rules relating to assignment of claims. Please refer to materials provided by each insurance company for limitations on assignment of claims.

***Time Limitations for Legal Actions:*** No action may be brought under ERISA in court prior to exhaustion of the administrative remedies described in this document. Each insurance company providing benefits through this Plan under insurance policies may have additional limits on filing legal actions. Please refer to materials provided by each insurance company.

***Applicable Law:*** This Plan is created and accepted in the State of Florida. All questions pertaining to the validity or construction of this Plan and of the acts and transactions of the parties hereto shall be determined in accordance with the laws of the State of Florida except as to matters governed by federal law. Each insurance company providing benefits through this Plan under insurance policies may have its own requirements relating to legal rights and applicable law. Please refer to materials provided by each insurance company.

# STATEMENT OF ERISA RIGHTS

As a participant in this 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 worksites and union halls, *all documents governing the plan,* including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the 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 description. The administrator may make a reasonable charge for the copies.

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

*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.

*Benefit from reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan*. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, 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 preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

*Prudent Actions by Plan Fiduciaries*

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

*Enforce Your Rights*

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days,

you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file 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. Information can also be obtained at the DOL's website, www.dol.gov.

# GLOSSARY

All capitalized terms used in this Summary Plan Description are used in the same manner as they are used and defined in the Plan Document:

**A.** **Bargaining Unit Employee** – An Employee who is a member of a bargaining unit covered under a Collective Bargaining Agreement negotiated by the Union, or by any other labor organization as may from time to time be accepted for participation under such terms and conditions as may be established by the Trustees.

**B.** **Board of Trustees** - The Board of Trustees of the Sheetmetal Workers Local Union No. 32 Health and Welfare Fund.

**C.** **Claims Administrator -** The person or entity designated by the Board of Trustees to adjudicate benefit claims on behalf of the Plan.

**D.** **Collective Bargaining Agreement** - An agreement between an Employer and a Union under which the Employer has agreed to make contributions to the Trust Fund on behalf of its Employees.

**E.** **Covered Employee -** An Employee who is eligible for benefits under this Plan.

F. **Covered Person** - A Covered Employee, Retiree and/or a covered Dependent. Also referred to as a Participant.

**G.** **Dependent** –

(a) The married spouse of a Covered Employee, while not divorced or legally separated from the Covered Employee.

(b) Each child of a Covered Employee, until the end of the year in which the child attains age 26, and as described further below.

(i) For the purpose of this section, the term "child" means a Covered Employee's natural child, adopted child, stepchild and/or foster child, as described in Section 152(f)(1) of the Internal Revenue Code.

(ii) In addition, "child" also means a child for whom there is a Qualified Medical Child Support Order which states that health care coverage must be maintained by a Covered Employee.

(c) Each child of a Covered Employee from the end of the year in which such child attains age 26 until the end of the calendar year in which the child attains age 30, if all of the following requirements are met:

(i) The Covered Employee has exercised his/her option to have said child insured,

(ii) The child is unmarried and does not have a dependent of his/her own,

(iii) The child is a resident of Florida or is a full-time or part-time student,

(iv) The child is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, franchise or individual health benefit plan, and

(v) The child is not entitled to benefits under Title XVIII of the Social Security Act.

**H.** **Employee** - Each person who is employed by an Employer and on whose behalf the Employer is required to make contributions to the Fund under the terms of a Collective Bargaining Agreement or a Participation Agreement.

**I.** **Employer -**

(a) An employer who is bound by a Collective Bargaining Agreement with the Union or by a Participation Agreement with the Trustees, to make payments to the Trust Fund with respect to Employees covered by said Collective Bargaining Agreement or Participation Agreement.

(b) A Union required to contribute to the Trust Fund on behalf of its employees, as agreed to by the Trustees and as set forth in a Participation Agreement.

(c) The Council, with respect to those employees on whose behalf it is required to contribute to the Trust Fund.

(d) The Trustees of the Trust Fund who contribute on behalf of Trust Fund employees, as set forth in a Participation Agreement.

(e) The trustees of any other trust fund established pursuant to a collective bargaining agreement who contribute on behalf of trust fund employees or trust fund participants, as agreed to by the Trustees and as set forth in a Participation Agreement.

**J.** **ERISA –** The Employee Retirement Income Security Act, 29 U.S.C. §1001, *et. seq., as amended*.

**K.** **Medicare** - The program established under Title XVIII of the Social Security Act (Federal Health Insurance for the Aged) as it is presently constituted or may hereafter be amended.

**L.** **Non-Bargaining Unit Employee** – Any employee of a contributing Employer who is a full-time salaried employee, officer or director of the contributing Employer, who is not covered under a Collective Bargaining Agreement, and upon whose behalf the Trustees have agreed to accept contributions pursuant to a written Participation Agreement.

**N.** **Participant** - A Covered Employee, Retiree, and/or a covered Dependent. Also referred to as a Covered Person.

**O.** **Participation Agreement -**

(a) An agreement between the Board of Trustees and an Employer that is obligated to make contributions to the Trust Fund on behalf of Employees covered under the terms of a Collective Bargaining Agreement, under which the Employer agrees to make contributions to the Trust Fund on behalf of the Employer's Non-Bargaining Unit Employees listed in the agreement, under the terms set forth in the agreement.

(b) An agreement between the Board of Trustees and a Union, the trustees of a trust fund, or an employer of Non-Bargaining Unit Employees, under which such union, trustees, employer or person agrees to make contributions to the Trust Fund on behalf of Non-Bargaining Unit Employees listed in the agreement, under the terms set forth in the agreement.

**P.** **Plan -** The Health and Welfare Plan of Sheetmetal Workers Local Union No. 32 Health and Welfare Fund and all amendments hereto.

**Q.** **Plan Administrator** - The Board of Trustees of the Plan.

**R.** **Plan Year** - The twelve (12) month period beginning on July 1 and ending June 30 of each calendar year.

**S.** **Schedule of Benefits** - A Schedule that describes benefits and cost sharing requirements, including copayments, coinsurance, deductible amounts and maximum benefit and payment limitations. There are different Schedules of Benefits for different types of benefits and for different benefit options.

**T.** **Third Party Administrator** - The person or entity designated by the Board of Trustees to perform plan administration functions for the Plan.

**U.** **Totally Disabled -**The term "totally disabled" means a disability resulting from disease or injury which completely and continuously prevents the Employee from performing any and every duty pertaining to his occupation or employment, and with respect to Dependents, the complete inability to perform the normal activities of a person of like age and sex.

**V.** **Trust Fund or Fund -**The entire trust estate of the Sheetmetal Workers Local Union No. 32 Health and Welfare Fund, as it may from time to time be constituted, including without limitation all funds received in the form of contributions, together with all contracts (including dividends, interest, refunds, and other sums payable to the Trustees on account of such contracts), earnings and profits therefrom, and any and all other property or funds received and held by the Trustees.

**W.** **Union** – Sheet Metal Workers Local Union No. 32 and such other labor organizations as may from time to time be accepted for participation under such terms and conditions as may be established by the Trustees.