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**Sheet Metal Workers' International Association  
Local Union 137, Insurance Plan**

21-42 44th Drive  
Long Island City, New York 11101  
(718) 937-4514

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Sheet Metal Workers'  
International Association  
Local Union No. 137  
21-42 44th Drive  
Long Island City, New York 11101

**Identification Number**

13-5520944

**Plan Sponsor Number**

501

**Type of Plan**

Health and Welfare

**Type of Plan Administration**

All Coverage: Self-Insured

**Plan Year**

January 1 - December 31

**Agent for Service of Legal Process**

Plan Administrator

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**TO ALL PARTICIPANTS AND BENEFICIARIES:**

We are pleased to present you with the revised Summary Plan Description of the provisions of your insurance plan. If you have any difficulty understanding any part of the following, please feel free to contact the Plan Office. Our Office hours are from 7:00 AM to 4:00 PM, Monday through Friday. Our telephone number is (718) 937-4514.

**THE PLAN:**

Insurance Plan Sheet Metal Workers International Association Local Union 137.

**ADMINISTRATION:**

The Plan is administered by a Joint Board of Trustees, composed of three (3) Union Trustees and three (3) Employer Trustees. The Plan Office is located at 21-42 44th Drive, Long Island City, New York 11101, telephone # (718) 937-4514. The Plan Administrator is the agent for service of legal papers and conducts business at the above address. The Plan is maintained under one or more Collective Bargaining Agreements. Employers make contributions in accordance with collective bargaining agreements between the Union and the Employer.

**THIRD PARTY ADMINISTRATOR**

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**ACTUARY/CONSULTANT**

First Actuarial Consulting Team  
1501 Broadway, Suite 1728  
New York, New York 10036

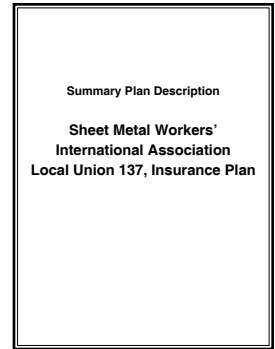
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# 1.

# Your Plan At A Glance



By using the network of hospitals, doctors and other health care providers, you will be entitled to maximum health care coverage. The chart below summarizes that coverage and is included here as a "quick reference." **Remember to refer to the balance of this Summary Plan Description for a more complete description of your coverage.**

## Health Care Coverage (For You And Your Covered Dependents)

**Medical Certification Program.** This Program requires that you call Alicare Medical Management (AMM) before you go into a hospital (or within 48 hours of an emergency admission), or if you are having any surgery. **If you do not notify AMM when required, your claims for those services will not be covered, or will not be covered in full.** The toll free telephone number to call AMM is 1-800-332-5426.

**If you have questions about out-of-network benefits, call Alicare at 212-539-5115 or the Plan Administrator.**

### Coverage When A Network Facility Is Used

### Coverage When A Network Facility Is Not Used

#### Basic Hospital Coverage

##### Hospital Inpatient:

Coverage For Plans A, 4, B, 3 and C .l

Room, Board and Ancillary Charges (Semi-Private)

100% of the network rate for up to 120 days or \$200,000<sup>1</sup>, whichever occurs first.

80% of the Plan's schedule for up to 120 days or \$200,000<sup>1</sup>, whichever occurs first.

Per confinement copay:  
\$20-Plan A  
\$10-Plan 4, B, 3, and C .

Per confinement copay:  
\$20-Plan A  
\$10-Plan 4, B, 3 and C.

##### Hospital Alternatives: Coverage For Plans A, 4, B, 3 and C only

- Ambulatory Surgical Center
- Skilled Nursing Facility
- Home Health Care
- Birthing Center

100% of the network rate subject to the 120 days or \$200,000<sup>1</sup> which ever occurs first.

80% of the Plan's schedule, subject to the 120 days or \$200,000<sup>1</sup> whichever occurs first.

Per confinement copay:  
\$20-Plan A  
\$10-Plan 4, B, 3 and C.

Per confinement copay:  
\$20-Plan A  
\$10-Plan 4, B, 3 and C.

**For both in-network and non-network copays, see details in section 3 (Health Care Coverage).**

<sup>1</sup> Network and non network hospital calendar year benefits are combined toward the maximum.

Coverage When A Network Facility Is Used

Coverage When A Network Facility Is Not Used

**Basic Hospital Coverage (continued)**

**Hospital Outpatient:** Coverage For Plans A, 4, B, 3 and C only

**Emergency Room**

Accident	100% of the network rate, subject to the following copays: <b>Plan A:</b> \$20 <b>Plans 4, B, 3, and C:</b> \$10	80% of the Plan's schedule, subject to the following copays: <b>Plan A:</b> \$20 <b>Plans 4, B, 3, and C:</b> \$10
Illness (Sudden & Serious) <sup>2</sup>	100% of the network rate after \$100 copay per visit.	80% of the Plan's schedule after a \$100 copay per visit.
Illness (Non Sudden & Serious) <sup>2</sup>	<b>Plan A only:</b> 100% of the network rate up to a family maximum benefit of \$200, subject to a \$100 copay per visit. This includes physician services.	No out of network benefit available for any Plans.
<b>Surgery</b>	100% of the network rate.	80% of the Plan's schedule

Coverage When A Network Provider Is Used

Coverage When A Network Provider Is Not Used

**Major Medical Coverage**

<b>Maximum Payment (Per Illness or Injury)</b>	<b>Plan A</b>	<b>Plan 4 &amp; B</b>	<b>Plan 3 &amp; C</b>	<b>Plan A</b>	<b>Plan 4 &amp; B</b>	<b>Plan 3 &amp; C</b>
	\$75,000	\$25,000	\$25,000			
<b>Calendar Year Deductible (Per person)</b>	<b>Plan A</b>	<b>Plan 4 &amp; B</b>	<b>Plan 3 &amp; C</b>	<b>Plan A</b>	<b>Plan 4 &amp; B</b>	<b>Plan 3 &amp; C</b>
	\$0	\$0	\$300	\$150	\$200	\$300
<b>Surgery Coverage Surgical Fees Assistant Surgeon</b>	<b>Plan A:</b> 100% of the network rate. <b>Plans B, 4, 3, &amp; C:</b> 80% of the network rate, subject to any applicable deductible.			80% of the Plan's schedule, subject to the calendar year deductible.		

<sup>2</sup> A true emergency is the sudden and unexpected onset of a serious condition or illness for which treatment cannot be delayed without the risk of losing your life or seriously or permanently impairing your health. For example, if you go to the emergency room as a result of cardiac pain, massive bleeding, poisoning, shock, severe or multiple injuries of a stroke, treatment will be covered. If you go to the emergency room with a condition that could be treated in a doctor's office, the hospital out-patient non-emergency visit benefit will be applicable.

Coverage When A Network  
Provider Is Used

Coverage When A Network  
Provider Is Not Used

Major Medical Coverage (continued)

<b>Maternity Coverage</b>	<p><b>Plan A:</b> 100% of the network rate.</p> <p><b>Plans 4 &amp; B:</b> 80% of the network rate, up to a maximum benefit of \$1,500.</p> <p><b>Plans 3 &amp; C:</b> 80% of the network rate, up to a maximum benefit of \$1,000.</p>	<p><b>Plan A:</b> 80% of the Plan's schedule, up to a maximum benefit of \$3,200, subject to the calendar year deductible.</p> <p><b>Plans 4 &amp; B:</b> 80% of the Plan's schedule, up to a maximum benefit of \$1,500, subject to the deductible.</p> <p><b>Plans 3 &amp; C:</b> 80% of the Plan's schedule, up to a maximum benefit of \$1,000, subject to the deductible.</p>
<b>Removal of Impacted Wisdom Teeth</b>	<p><b>Plan A:</b> 100% of the network rate.</p> <p><b>Plans B, 4, 3, &amp; C:</b> 80% of the network rate, subject to any applicable deductible.</p>	<p>80% of the Plan's schedule, subject to the calendar year deductible.</p>
<b>Second Surgical Opinion</b>	<p><b>Plan A only:</b> 100% of the network rate up to a maximum benefit of \$300.</p>	<p><b>Plan A only:</b> 80% of the Plan's schedule up to \$300 maximum payment.</p>
<b>Anesthesiology<sup>3</sup></b>	<p><b>Plan A:</b> 100% of the network rate.</p> <p><b>Plans 4 &amp; B:</b> 80% of the network rate.</p> <p><b>Plans 3 &amp; C:</b> 80% of the network rate, subject to the deductible.</p>	<p><b>Plan A:</b> 80% of the Plan's schedule, payable at 30%, subject to the deductible.</p> <p><b>Plans 4, B, 3 &amp; C:</b> 80% of the Plan's schedule, payable at 24%, subject to the deductible.</p>
<b>Physician Inpatient Hospital, Home &amp; Office Visits</b>	<p><b>Plan A:</b> \$1,500 maximum payment per calendar year in &amp; out of network; \$20 copay, then 100% of the network rate.</p> <p><b>Plans B &amp; 4:</b> \$750 maximum payment per calendar year in and out of network; \$10 copay, then 80% of the network rate.</p> <p><b>Plans 3 &amp; C:</b> \$10 copay, then 80% of the network rate, subject to the deductible.</p>	<p><b>Plan A:</b> \$1,500 maximum payment per calendar year in &amp; out of network; \$35 basic benefit, then 80% of the Plan's schedule, subject to the \$20 copay and the deductible.</p> <p><b>Plans B &amp; 4:</b> \$750 maximum payment per calendar year in and out of network; \$20 basic benefit, then 80% of the Plan's schedule, subject to the \$10 copay and the deductible.</p> <p><b>Plans 3 &amp; C:</b> \$10 copay, then 80% of the Plan's schedule, subject to the deductible.</p>

<sup>3</sup>See details of the Anesthesia benefit for when you qualify for an enhanced benefit.

Coverage When A Network Provider Is Used

Coverage When A Network Provider Is Not Used

Major Medical Coverage (continued)

Physician Emergency Room Visits

Accident/Sudden & Serious Illness

**Plan A:** 100% of the network rate subject to \$20 copay.

**Plan A:** 80% of the Plan's schedule, subject to \$20 copay and deductible. However, if facility is in network, copay and deductible are waived.

**Plans B, 4, 3 & C:** 100% of the network rate subject to \$10 copay and any applicable deductible.

**Plans B, 4, 3 & C:** 80% of the Plan's schedule, subject to \$10 copay and deductible. However, if facility is in network, copay and deductible are waived.

Non Sudden & Serious Illness

**Plan A only:** 100% of the network rate up to a family maximum benefit of \$200, subject to a \$100 copay per visit. This includes emergency room facility charges.

No out of network benefit available for any Plans.

Well Child Care

**Plan A only:** Plan A dependents to 5th birthday only: \$20 copay, then 100% of the network rate for up to 5 visits per calendar year, provided immunizations are given during a well care visit.

**Plan A only:** Plan A dependents to 5th birthday only: \$20 copay, then 80% of the Plan's schedule up to a \$40 maximum payment per visit, for up to 5 visits per calendar year, provided immunizations are given during a well care visit.

Well Care/ Immunizations (1 visit per year)

**Plan A only:** Plan A dependents age 5 thru 18 (19-24 for full time student): \$20 copay, then 100% of the network rate provided immunizations are given during that well care visit.

**Plan A only:** Plan A dependents age 5 thru 18 (19-24 for full time student): \$20 copay, then 80% of the Plan's schedule, up to \$40 maximum payment per visit, provided immunizations are given during that well care visit.

Flu Shot

**Plans A, B, 4, 3 & C:** 100% of the network rate.

**Plans A, B, 4, 3 & C:** 100% of the Plan's schedule, subject to deductible.

Coverage When A Network Provider Is Used

Coverage When A Network Provider Is Not Used

Major Medical Coverage (continued)

<b>Annual Physical Exam (Once each year)</b>	<b>Plan A, participants &amp; spouses: Plans B &amp; 4, participants only:</b> 100% of the network rate up to \$300 toward the cost of exam and diagnostic tests. Exam at Professional Medical Evaluation Group health center with no out of pocket costs.	<b>Plan A, participants &amp; spouses: Plans B &amp; 4, participants only:</b> Up to \$200 toward the cost of exam and diagnostic tests.
<b>Chiropractic Visits</b>	<b>Plan A only:</b> \$20 maximum payment per visit. Up to 20 visits per calendar year, combined in and out of network.	<b>Plan A only:</b> \$20 maximum payment per visit. Up to 20 visits per calendar year, combined in and out of network.
<b>Allergy Treatment</b>	<b>Plan A:</b> 100% of the network rate up to \$600 maximum payment per calendar year combined in and out of network.	<b>Plan A:</b> 100% of the Plan's schedule up to \$600 maximum payment per calendar year combined in and out of network.
	<b>Plan B:</b> 100% of the network rate up to \$100 maximum payment per calendar year combined in and out of network.	<b>Plan B:</b> 100% of the Plan's schedule up to \$100 maximum payment per calendar year combined in and out of network.
<b>X-Ray, Laboratory and Diagnostic Testing<sup>4</sup> (See detail section for applicable copays)</b>	<b>Plan A:</b> 100% of the network rate.	<b>Plan A:</b> 100% of the Plan's schedule up to a maximum benefit of \$700, subject to the deductible.
	<b>Plans 4 &amp; B:</b> 100% of the network rate up to a maximum benefit of \$400, <sup>4</sup> then 80% of the network rate.	<b>Plans 4 &amp; B:</b> 100% of the Plan's schedule up to a maximum benefit of \$400, <sup>4</sup> subject to the deductible.
	<b>Plans 3 &amp; C:</b> 100% of the network rate up to a maximum benefit of \$150, <sup>4</sup> subject to the deductible, then 80% of the network rate.	<b>Plans 3 &amp; C:</b> 100% of the Plan's schedule up to a maximum benefit of \$150, <sup>4</sup> subject to the deductible.
<b>Physical Therapy (outpatient only)</b>	<b>Plans A:</b> 100% of the network rate.	<b>Plan A only:</b> 80% of the Plan's schedule, subject to the deductible.
	<b>Plans 4 and B:</b> 80% of the network rate.	No out of network benefit available for Plans 4, B, 3 and C.
	<b>Plans 3 and C:</b> 80% of the network rate, subject to the deductible.	

<sup>4</sup>See detail section of the X-ray, Laboratory and Diagnostic Testing benefit for applicable copays.

Coverage When A Network Provider Is Used

Coverage When A Network Provider Is Not Used

Major Medical Coverage (continued)

<b>Psychotherapy</b>	<p><b>Plans A, 4, B, 3 &amp; C:</b>                      Inpatient:  <b>Plan A:</b> 100% of the network rate, subject to \$20 copay;  <b>Plans 4, B, 3 &amp; C:</b> 80% of the network rate, subject to \$10 copay and applicable deductible.</p> <p>Outpatient: \$40 payment per visit for 50 visits after the applicable Plan copay.</p>	<p><b>Plans A, 4, B, 3 &amp; C:</b>                      Inpatient: \$40 maximum payment per visit.</p> <p>Outpatient: \$40 payment per visit for 50 visits after the applicable Plan copay.</p>
<b>Outpatient Substance Abuse Therapy</b>	<p><b>Plan A Journeymen only:</b><sup>5</sup>                      100% of the network rate to \$15,000 lifetime maximum payment per family.</p>	<p><b>Plan A Journeymen only:</b><sup>5</sup>                      80% of the Plan's schedule, subject to the deductible to \$12,000 lifetime maximum payment per family.</p>
<b>Air Ambulance</b>	<p>Fees for air ambulance transport in life or death situations will be covered under the Plan subject to medical necessity and Plan maximums.</p>	
<b>Medical Supplies</b>	<p>100% of the network rate.</p>	<p>80% of the Plan's schedule, subject to the deductible.</p>
<b>Private Duty Nursing</b>	<p>100% of the network rate.</p>	<p>80% of the Plan's schedule, subject to the deductible.</p>
<b>Dental Treatment For Accidental Injury To Natural Teeth</b>	<p>100% of the network rate.</p>	<p>80% of the Plan's schedule.</p>
<b>Special Service Benefits</b>	<p><b>Plan A: (For participants, dependents &amp; participants who are retired)</b>  <b>Plans B &amp; 4 (For participants only)</b>                      100% of the network rate to \$1,300 maximum payment per person per calendar year for:</p> <ul style="list-style-type: none"> <li>• blood and its transfusion</li> <li>• ambulance service</li> <li>• oxygen</li> <li>• rental of crutches</li> <li>• rental of a wheel chair</li> <li>• rental of a hospital bed at home</li> <li>• therapeutic devices and appliances such as orthopedic shoes, support garments, etc.</li> </ul>	

<sup>5</sup>See detail section of the Outpatient Substance Abuse benefit for pre-certification and eligibility requirements.

**For the following benefits -- Please be sure to read their detail sections.**

## **Optical Coverage (For You And Your Covered Dependents & Participants Who Are Retired)**

Coverage is provided for an examination and glasses once each calendar year as follows:

**Plans A, 4, B, 3 & C:** no cost with voucher provided by the Plan Office.

If no vouchers:

**Plan A:** \$30 for Ophthalmologist, \$25 Optometrist, \$30 glasses.

**Plans 4 & B:** \$25 for Ophthalmologist, \$15 Optometrist, \$25 glasses.

**Plans 3 & C:** \$20 for Ophthalmologist, \$20 Optometrist, \$10 glasses.

## **Hearing Aid Coverage (For Plan A Participants & Eligible Participants Who Are Retired)**

Hearing Aid coverage is provided after a \$100 deductible, up to a \$1,500 maximum payment once every five years with a physician's recommendation.

## **Dental Care Coverage (For You And Your Covered Dependents)**

Dental coverage<sup>6</sup> is provided up to the following maximum payments:

**Plan A:** \$1,500 per eligible family member per year.

**Plans 4 & B:** \$1,000 per eligible family member per year.

**Plans 3 & C:** \$800 per eligible family member per year.

**Plan A:** Orthodontic Benefit to \$500 lifetime maximum benefit per eligible family member

By accessing a provider in the Dental Guard Preferred Select Network, benefits will be paid at 100% of the Guardian Network rate. By using a provider out of the Network, benefits will be paid at 60% of billed charges.<sup>7</sup>

## **Prescription Drug Coverage (For You And Your Covered Dependents & Participants Who Are Retired)**

Covered for a 30 day supply, with a \$5 copay for generic drugs, a \$25 copay of brand name drugs with no generic available and a \$25 copay plus the difference in cost between the generic drug and brand name for brand name drugs when a generic is available.

## **Death Benefits (For Participants And Participants Who Are Retired)**

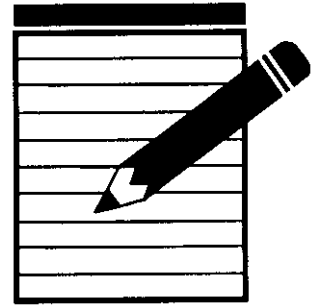
	<b>Plan A</b>	<b>Plan 4</b>	<b>Plan B</b>	<b>Plan 3</b>	<b>Plan C</b>
Eligible Active Member up to 69 years	\$50,000	\$10,000	\$10,000	\$10,000	\$10,000
Eligible Active Member 70 years or older	\$10,000	\$5,000	\$5,000	\$5,000	\$5,000
Eligible Retired Member up to 69 years	\$10,000	\$10,000	\$5,000	\$5,000	\$5,000
Eligible Retired Member 70 years or older	\$5,000	\$2,500	\$2,500	\$2,500	\$2,500

<sup>6</sup> Removal of impacted wisdom teeth (full, partial bony, soft tissue) will be covered under the medical plan's surgical benefit.

<sup>7</sup> To find a participating provider, check on line at [www.guardianlife.com](http://www.guardianlife.com) and choose the Dental Guard Preferred Select Network. You can also call Alicare at (212) 539-5115.

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## **2.** Basic Information



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### **Sheet Metal Workers' International Association**

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The security of your family is an important concern to your employer and your union. Without adequate protection, the costs of an illness or injury could become an impossible financial burden.

Naturally, the hope is that serious illness or injury never comes your way. However, as a participant of the Sheet Metal Workers' International Association-Local Union 137, you can be assured that you and your family have the protection you need through a wide range of coverage.

The Plan described in this booklet is effective for participants of the Plan who are covered by a collective bargaining agreement between the union and employers, which provides for the appropriate contributions for this coverage.

### **How To Use This Booklet**

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This booklet is called a Summary Plan Description. It is designed to help you understand how your Plan works. Because certain parts of the Plan are complicated, every effort has been made to present this material in a way that is easy to understand.

To assist you in understanding your coverage, there are summary charts throughout the booklet and a general overview at the beginning of the booklet. However, it is important for you to read the entire booklet to fully understand what you are entitled to, so that you can make the best use of your Plan coverage.

If after reading this booklet you have any questions about the Plan and how its coverage works, the Plan Office will be glad to help you.

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# Who Is Covered?

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**YOU:** When you meet the Plan's requirements for coverage (see next section).

**YOUR ELIGIBLE DEPENDENTS:** The only persons who are recognized by this Plan, as dependents are the following:

- The legally married spouse of a participant. A dependent spouse becomes ineligible for medical benefits on the date of divorce or legal separation from a covered participant. In addition, the participant must notify the Plan office immediately or be responsible for any and all claims paid on behalf of the ineligible spouse.
- Unmarried children, legally adopted children, stepchildren and foster children (provided proof has been submitted to the Plan office that they live with you and depend on you for full support) under 19 years of age except in the event that an unmarried dependent child is mentally retarded or physically handicapped coverage will continue after the child attains the age of 19. Unmarried dependent children, who are not employed full time, who are dependent upon you for full support and who are enrolled as a full time student in an accredited college will be eligible for coverage through the age of 23. Proof of registration and attendance at an accredited college must be submitted to the Plan office within 31 days of original enrollment and once each semester thereafter. Employment during a school vacation or part time employment at the educational institution shall not disqualify a dependent child from this coverage.

## **Dependent Children's Coverage Required by Qualified Medical Child Support Orders:**

The Plan is required to recognize Qualified Medical Child Support Orders (QMCSO). QMCSO require health plans to recognize State court orders, which the Plan determines to be Qualified Medical Child Support Orders as defined by Federal law. A QMCSO requires the Plan to provide coverage to an Eligible Participant's Child even if the Participant does not have custody of the child. A QMCSO is a judgment, decree, or order issued by a court of competent jurisdiction or by a state administrative body that has the force of a court judgment, decree, or order. To be a QMCSO a judgment, decree, or order must require the child to be enrolled in the Plan; as a form of child support or health benefit coverage, pursuant to state domestic relations law or enforce a state law relating to medical child support.

The order must include:

- The name and last known mailing address (if any) of the Participant and the names and mailing address of each child covered by the order,
- A reasonable description of the type of coverage to be provided by the Plan (within the limits of the Plan),
- The period of coverage to which the order pertains, and
- The name of the Plan

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Such an order is not "qualified" if it requires the Plan to provide any type or form of Benefit not otherwise provided under the Plan except to the extent necessary to comply with a state law relating to medical child support orders. Upon receipt of an order, the Plan shall notify, in writing, the Participant and each child covered by the order submitted for determination as to whether it is a "Qualified Medical Child Support Order" and of the Plan's procedures for determining whether the order is qualified, in writing, as soon as administratively possible.

## When Coverage Begins

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**HOW TO APPLY FOR BENEFITS:** To qualify for and receive prompt payment of benefits, you must follow the rules and procedures set forth below.

**ENROLLMENT:** An enrollment card (designation of beneficiary) listing your eligible dependents (spouse, children) which also designates your Beneficiary must be on file in the Plan Office. You may change your beneficiaries at any time by filing a new designation of beneficiary card with the Plan office.

**Any change in your family status (marriage, death, divorce, legal separation or birth, etc.) must be reported to the Plan Office no later than 10 days after the occurrence.**

**ELIGIBILITY:** In order to be eligible for benefits during any 6 month roll-over period you must work at least 300 hours in a six (6) month roll-over period.

**For example:**

Months and Hours worked:

JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN
160	160	80	80	40	40	0	40	40	140	140	160	0

First 6 month roll over period begins January thru June - total contribution hours are 560 - you need 300 to be eligible - you are eligible for coverage in July.

Second 6 month roll over period begins February thru July - Total contribution hours are 400 - you need 300 to be eligible - you are eligible for coverage in August.

Third 6 month roll over period begins March thru August - Total contribution hours are 280 - you need 300 to be eligible - you are NOT eligible for coverage in September.

Fourth 6 month roll over period begins April thru September - total hours are 200 - you need 300 to be eligible - you are NOT eligible for coverage in October.

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Fifth 6 month roll over period begins May thru October - total hours are 300 - you are eligible for coverage in November.

For each 6 month roll over period coverage in the seventh month is in question.

**FOR NEW PARTICIPANTS AND NEW GROUPS OF THE PLAN:**

A new participant becomes eligible for benefits on the first day of the 7th month after the later of your hire date and the date your employer first becomes obligated to make contributions to this Plan, provided you achieve 6 months of consecutive contributions beginning with the month you first work through the following 5 consecutive months (example: If you are hired in January and work continuously through June, you would be covered in July). Maintaining that coverage is based on 300 hours in a six month rollover period as explained on the previous page.

**FOR DISABLED PARTICIPANTS:** Participants that were eligible under the rules of the Plan and are unable to work because of a work related or non-work related disability shall be eligible for continued coverage for a period of twelve (12) months from the date last worked provided that such disability commenced after eighteen (18) continuous months of employment with a contributing employer. The Participant must submit proof of receipt of coverage by state disability or workers' compensation on a monthly basis to the Plan office in order to be eligible for continuing coverage.

If a participant returns to covered employment during the 12 month work related or non-work related disability, The Fund Office will look back to the four (4) months prior to the participant's injury and if the participant worked a minimum of three hundred (300) hours in that four month period then he will be eligible for regular coverage (without paying COBRA), beginning on the first day of the month he returns to work after his/her injury.

If, in the 13th month the participant is still not able to return to work, the participant will be eligible to elect continuing coverage under COBRA self-pay arrangement at the rate then prevailing. Continued coverage under COBRA will be available for eighteen (18) months or whatever period required by law. If the participant returns to covered employment during the COBRA coverage period, the participant must be employed for four (4) months and work a minimum of three hundred (300) hours under covered employment to be eligible for regular coverage beginning the first day of the fifth (5th) month of employment. Coverage under COBRA may continue until the participant becomes eligible for coverage after three hundred (300) hours of covered employment so long as the COBRA coverage does not exceed the maximum period allowed by law.

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## Exclusion For Pre-Existing Conditions

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A “pre-existing condition” is any condition other than pregnancy for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period immediately preceding the date upon which contributions are first made on behalf of you and/or your eligible dependents. If you or your eligible dependents have a pre-existing condition, the Plan will not cover the condition for 12 months. This 12 month period is reduced by periods of prior coverage which were not separated by more than 63 days.

For example, if you were covered under your previous plan for 9 months, your pre-existing conditions exclusion only applies for 3 months. If you were covered for one year or longer, your pre-existing condition exclusion is waived entirely.

This provision applies only to medical benefits that are covered by the Plan, and which were also covered by your previous plan.

## Extension Of Coverage For Participants Who Are Retired

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### **A. For Participants who retire under 55/30:**

The Plan will cover the participant until he or she is eligible for Medicare Benefits provided he or she:

- Is in receipt of a 55/30 pension benefit from the National Pension Plan, and
- Was eligible for benefits immediately prior to retirement, and
- Maintained contributions made to Local Union 137’s Insurance Plan for at least 30 years prior to retirement.

### **B. For Participants who initially retire between ages 60 & 65:**

The Plan will provide the coverage for a participant who is retired provided he or she:

- Was in receipt of a retirement benefit from the National Pension Plan and
- Was eligible for benefits immediately prior to retirement and
- Maintained contributions made to Local Union 137’s Insurance Plan for at least 30 years prior to retirement.

### **C. For Participants who initially retired between ages 55 and 60:**

The Plan will offer COBRA coverage for this participant until he or she is eligible for Medicare Benefits provided he or she:

- Was in receipt of a retirement benefit from the National Pension Plan, and

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- Was eligible for benefits immediately prior to retirement, and
  - Maintained contributions made to Local Union 137's Insurance Plan for at least 30 years prior to retirement.

At the time a participant who is retired becomes eligible for Medicare benefits, he or she will also be eligible for the SPECIAL PROGRAM OF BENEFITS FOR PARTICIPANTS WHO ARE ELIGIBLE FOR MEDICARE SUPPLEMENT. A retired participants spouse may purchase COBRA coverage until that spouse attains the age of eligibility for Medicare Benefits. The COBRA rate will be increased to 120% of the then current rate for any participant and/or dependent who continues to purchase COBRA beyond five (5) years (beginning with the 61st payment).

If your spouse is currently covered under other insurance which he or she cannot opt out of until the open enrollment period in the same year, that spouse can elect to continue coverage under COBRA from the first day of retirement, provided we receive proof of the open enrollment period and proof of termination. The coverage provided under COBRA is secondary to the other insurance until that insurance is terminated.

In the event that the participant who is retired passes away the spouse may continue to purchase COBRA for eighteen months.

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# When Coverage Ends

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Your eligibility for benefits will terminate on the day you leave the industry or:

- Are not available to work, or
- Withdraw from Local Union 137, or
- Work outside the jurisdiction of Local Union 137, except that you will continue to be covered for all benefits, during any period of temporary employment outside the jurisdiction to Local Union 137, not in excess of six months. For purposes of this section, all periods of employment outside the jurisdiction of Local Union 137 shall be deemed by Employers contributing to this Plan.

If your eligibility for benefits is terminated and you again become employed within the jurisdiction of Local Union 137, you will be treated as a new participant and you will have to again satisfy all the requirements for ELIGIBILITY. However, if you are terminated and again become employed in the jurisdiction of Local Union 137 within six months you will be eligible for all benefits once you reach 300 hours in a six (6) month roll over period.

If you become disabled and are unable to work before age 65 and you have at least 25 consecutive years of contributions made to the Local 137 Insurance Plan on your behalf, you and your dependents will remain eligible for all benefits, for a period of twelve months from the date of the disability or until the age of 65, which ever shall first occur.

## Certificate Of Creditable Coverage

When your (and your covered dependents') coverage under the Plan ends, the Plan will issue a Certificate of Creditable Coverage to each individual or family participant whose coverage ends. The Certificate provides the documentation of prior coverage and /or limitations when enrolling in a new employer-sponsored health plan.

The Plan must provide you with a Certificate:

- when you lose coverage under the Plan or COBRA continuation coverage terminates;
- if requested, before losing coverage or within 24 months of losing coverage.

The Certificate of Creditable Coverage indicates:

- if you and/or your family had up to 18 months of creditable coverage under the Plan;
- the coverage start date (along with any eligibility waiting period);
- the coverage end date under the Plan.

If, within 63 days after your coverage under the Plan ends, you and/or your eligible dependents become eligible for coverage under another group health plan, or if you buy an individual insurance policy, the Certificate of Coverage may be necessary to reduce a pre-existing limitation period that may apply under the new Plan.

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# The Uniformed Services Employment and Reemployment Rights Act of 1994

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If you stop working to enter Military Service, all benefits will terminate on the date you leave active employment. However, the Uniformed Services Employment and Reemployment Rights Act of 1994 enables you to continue your coverage for a period of time, and to be guaranteed reinstatement upon your return to work.

## Continuation Coverage

Participants on uniformed service leave and their dependents who are covered by the Plan at the time leave begins may be eligible for continued health coverage while they are on leave for up to 18 months, beginning on the date on which the participant's absence for such leave commences. See "Your COBRA Rights" for more information on the availability of continuation coverage.

### **Effective with COBRA elections on and after December 10, 2004:**

The Veteran's Benefits Improvement Act of 2004 extends the 18 month extension of coverage period offered under COBRA to 24 months beginning on the date on which the participant's absence for such leave commences.

## Reinstatement of Health Coverage

If your health coverage under the Plan is terminated by reason of service in the uniformed services, you are entitled to reinstatement of health coverage for yourself and your dependents upon your return to employment with your Employer, without the application of any waiting periods and pre-existing conditions limitations. The Plan may apply a waiting period or pre-existing conditions period for disabilities that the Veteran's Administration ("VA") has determined to be service connected. This includes any injury or sickness found by the VA to have been incurred in, or aggravated during, the performance of service in the uniformed services.

The term "uniformed services" refers to the United States Armed Services (including the Coast Guard), the Army National Guard and the Air National Guard (when engaged in active duty for training, inactive duty training, or full-time National Guard duty), the commissioned corps of the Public Health Service, and any other categories of covered services that the President of the United States may determine.

The term "service in the uniformed services" means the performance of a duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National

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Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

### **Honorable Discharge**

All of the rights granted by the Uniformed Services Employment and Reemployment Rights Act of 1994 are dependent on uniformed service that ends honorably. Separation from the uniformed services that is dishonorable or based on bad conduct, on grounds less than honorable, AWOL, or ending in conviction under court martial, would disqualify a service participant from any of the rights under the law.

## **Continuing Eligibility During Family And Medical Leave Act**

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The Family and Medical Leave Act of 1993 (FMLA) entitled participants eligible under the Act to take up to 12 weeks of unpaid, job-protected leave each year for the participant's own illness, or to care for a seriously ill child, spouse or parent.

In addition, the FMLA provides leave for the birth of a child of the Participant or placement of a child with the Participant in the case of adoption or foster care. Participants eligible for leave under the FMLA are those who have been employed at least 12 months by an employer and who have provided at least 1,250 hours of service to the employer. A Participant at a work site where there are less than 50 employees is not eligible for FMLA leave unless the total number of employees of that employer within a 75 mile radius of that Participant equals or is greater than 50.

Employers covered by the FMLA are required to maintain medical coverage for participants on FMLA leave whenever such coverage was provided before the leave was taken, and on the same terms as if the participant had continued to work. This means that an Employer is required to continue making contributions to the Plan on behalf of Participants while they are on FMLA leave.

Participants should contact the Plan Office if they are planning to take FMLA leave so that the Plan is aware of the Employer's responsibility to report and contribute during the FMLA leave. However, any dispute between the Participant and the Employer concerning the application of FMLA to the Participant's leave or the obligation of the Employer must be resolved between the Participant and Employer. Participants with questions about the FMLA should contact their Employer or the nearest office of Wage and Hours Division, listed in most telephone directories under U.S. Government, Department of Labor, and Employment Standards Administrations.

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# 3.

# Health Care Coverage



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## Introduction

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**BLUE CROSS BLUE SHIELD network of providers:** The Trustees have entered into an agreement with a Network of physicians; this network of practitioners accepts as payment in full a schedule of allowances that is substantially lower in the New York/New Jersey area. Utilization of the network's physicians therefore will result in less out-of-pocket expense to the participant. The network consists of General Practitioners, Surgeons, Radiologists, Cardiologists, Anesthesia, Laboratories, and Hospitals. The network is available to all eligible participants and their dependents. When using an in-network provider for a covered service the only responsibility to the participant is the co-payment, subject to the limitations noted herein.

Questions about your eligibility should be directed to The Plan Office at 1-718-937-4514.

Questions about the Network or about claims issues with Network doctors should be directed to the Managed Care HelpLine at 1-800-725-9214.

**PLAN BENEFITS:** The Plan benefits to which you may be entitled are determined by the rate of monthly contributions that are being made on your behalf by contributing employers.

Based upon the contributions made on your behalf in accordance with the present collective bargaining agreement you are covered by benefits described in Plan A, B, 4, C, or 3.

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# Medical Certification Program

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The Medical Certification Program is a cooperative effort in which Alicare Medical Management's (AMM's) medical professionals work with you, your family, your doctor and hospital to assure you of the highest quality care and to help eliminate unnecessary surgeries and unnecessary days in the hospital.

The Medical Certification Program requires that you and your covered dependents call AMM in the following situations:

- If you are going to be confined as an inpatient in a hospital, as soon as your admission date has been scheduled.
- If you are admitted to the hospital on an emergency basis, within 48 hours after the admission. If you are unable to call within 48 hours, call as soon as possible after the admission.
- If you are having elective surgery, whether performed in a hospital or on an outpatient basis.

AMM's doctors and/or nurses will contact your doctor and your hospital to provide a professional review of your treatment and determine that the care you receive is medically necessary and delivered in the appropriate setting for your treatment.

Failure to comply with the Plan's Medical Certification Program could result in the Plan's denial of benefits.

The toll free telephone number to call AMM is **1-800-332-5426**.

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# Using The Network

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When you call to make an appointment with your doctor or other health care provider, be sure to identify yourself as a Sheet Metal Workers' International Association Local Union 137 Insurance Plan participant and give the name of your network provider. Bring your health benefit plan identification card with you each time you visit the provider. For your first visit, bring:

- notes about your family and personal medical history
- a list of all medications you are taking
- a list of your past hospitalizations, if any, and the dates of those visits
- your immunization records
- a record of your last tuberculin skin test.

Be prepared to discuss your current medical problem or condition.

When any referral is made, remind your doctor that you prefer to go to a network provider, if possible.

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# Basic Hospital Coverage

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## SUMMARY

Coverage For:

- 120 days or \$200,000 (whichever occurs first)
- Semi-private room and board
- Hospital billed ancillary services and supplies

For eligible participants of Plans A, 4, B, 3 and C.

Hospital inpatient facilities and hospital billed services and supplies are covered up to 120 days or \$200,000, whichever occurs first for each covered illness or injury.

Coverage is provided for:

- semi-private room accommodations
- other Hospital billed charges for eligible participants and dependents of Plans "A", "4", "B", "3" and "C" such as operating room, intensive care units, medicines, drugs, anesthesia, x-ray examinations, treatments with x-ray, radium and other radioactive substances, laboratory tests, local ambulance service, surgical dressings and supplies AND
  - Room and Board including special diets.
  - General Nursing services.
  - Use of operating, cystoscopic, recovery rooms, and equipment.
  - Laboratory and x-ray equipment consistent with the diagnosis and treatment for the condition for which hospitalization is required.
  - Drugs and medicines used in the hospital, except blood and blood plasma.
  - Oxygen and use of equipment for administering oxygen.
  - Anesthesia supplies and use of anesthesia equipment.
  - Dressings and Plaster casts.
  - Basal metabolic examinations.
  - Use of cardio graphic equipment.
  - Use of physiotherapist equipment.
  - Use of blood transfusion equipment and administration of blood only by an employee of the hospital.

Coverage is provided on the following basis:

- **If you use a Network hospital:** Covered at 100% of the network rate after the following per confinement copayments:
  - \$20 - Plan A
  - \$10 - Plans 4, B, 3 and C.
- **If you do not use a Network hospital:** Covered at 80% of the Plan's schedule after the following per confinement copayments:
  - \$20 - Plan A
  - \$10 - Plans 4, B, 3 and C.

The Plan DOES NOT provide Hospital Expense Benefits for confinement for functional nervous or mental disorders, special nurses, physicians or surgeons' services, dental work, accidents or

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sickness covered by Worker's Compensation Legislation, maternity benefits for dependent children, treatment for alcohol and drug abuse, admissions for rehabilitation, physical therapy, custodial care, rest homes or hospitalization furnished by a Federal or State agency.

### **Newborns' and Mothers' Health Protection Act**

Group health plans and health insurance issuers offering group health insurance coverage 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 normal vaginal delivery, or less than 96 hours following a caesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. 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). Federal law prohibits plans and insurers from requiring that authorization be obtained from the plan for prescribing a length of stay not in excess of 48 or 96 hours.

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# Alternatives To Hospital Inpatient Coverage

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**Hospital Alternatives other than Birthing Centers only apply to Plans A, 4, B, 3 and C**

The Plan provides coverage for the use of health care facilities, services and supplies that can be used in place of traditional hospital inpatient care.

The availability of these alternatives provides a high quality health care environment which may be most appropriate to the specific needs of the patient's medical condition. To be covered, facilities must meet the Plan's guidelines for approved facilities.

You should discuss the appropriateness of these alternatives to hospital inpatient care with your doctor, the Social Services Department of the hospital, or Alicare Medical Management.

## **Ambulatory Surgical Center**

An ambulatory surgical center is a hospital affiliated program or a free standing facility where certain surgical procedures are performed on a one day, or ambulatory basis. These facilities, which are also known as surgi-centers and short procedure units (SPUs), are equipped to handle many surgeries now being performed on an inpatient basis.

Coverage is provided in lieu of hospital inpatient coverage, subject to the 120 days or \$200,000 maximum, whichever comes first, for each covered illness or injury.

Coverage is provided on the following basis:

- **If you use a Network facility:** Covered at 100% of the network rate after the following per confinement copayments:  
\$20 - Plan A  
\$10 - Plans 4, B, 3 and C.
- **If you do *not* use a Network facility:** Covered at 80% of the Plan's schedule after the following per confinement copayments:  
\$20 - Plan A  
\$10 - Plans 4, B, 3 and C.

## **Skilled Nursing Facilities**

A skilled nursing facility is a specially licensed institution (or part of an institution such as a hospital) which allows patients to recover in an environment devoted to rehabilitation. A skilled nursing facility is appropriate for patients who need specialized care on a daily basis, but no longer need to be confined to a hospital.

Coverage is provided for short-term rehabilitation during the acute stages of an illness or injury when a physician has determined that

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therapy will result in a significant improvement in the acute condition within a specified time period.

Confinements for rehabilitation and rehabilitation services billed by the facility, are limited to those services provided to correct an impairment due to accident or sickness, or a congenital defect for which corrective surgery has been performed.

Coverage is provided in lieu of hospital inpatient coverage, subject to the 120 days or \$200,000 maximum, whichever comes first, for each covered illness or injury.

Coverage is provided on the following basis:

- **If you use a Network facility:** Covered at 100% of the network rate after the following per confinement copayments:  
\$20 - Plan A  
\$10 - Plans 4, B, 3 and C.
- **If you do not use a Network facility:** Covered at 80% of the Plan's schedule after the following per confinement copayments:  
\$20 - Plan A  
\$10 - Plans 4, B, 3 and C.

## Home Health Care

Home health care, when provided by a licensed public or private agency which specializes in providing therapeutic services at home, allows the patient to recover from an illness at home rather than spending unnecessary time in the hospital.

Coverage is provided in lieu of hospital inpatient coverage, subject to the 120 days or \$200,000 maximum, whichever comes first, for each covered illness or injury, if the following conditions are met:

- the patient was confined to a hospital or skilled nursing or acute rehabilitation facility for at least three consecutive days (not including the day of discharge) and within 14 days of receiving home health care, and
- the home health care was for treatment of the same condition that was treated in the hospital, and
- the patient's physician certifies that without home health care a continued hospital or skilled nursing or acute rehabilitation facility confinement would be necessary, and
- the patient is confined to home.

The Plan covers the charges of a home health care agency for the following services and supplies:

- professional visits by a registered nurse or licensed practical nurse (not full-time care)

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- physical, speech or occupational therapy
  - medical social services under the direction of a physician
  - medical supplies which would have been required in the hospital
  - use of medical appliances.

Coverage is provided as follows:

- **If you use a Network facility:** Covered at 100% of the network rate after the following per confinement copayments:  
\$20 - Plan A  
\$10 - Plans 4, B, 3 and C
- **If you do not use a Network facility:** Covered at 80% of the Plan's schedule after the following per confinement copayments:  
\$20 - Plan A  
\$10 - Plans 4, B, 3 and C.

### **Birthing Centers**

A birthing center is a free standing facility or hospital affiliated program which provides maternity care for uncomplicated deliveries. A birthing center usually provides a home-like atmosphere and encourages a one day stay.

Coverage is subject to the 120 days or \$200,000 maximum, whichever comes first, for each covered illness or injury.

Coverage is provided on the following basis:

- **If you use a Network facility:** Covered at 100% of the network rate after the following per confinement copayments:  
\$20 - Plan A  
\$10 - Plans 4, B, 3, C and 2.
- **If you do not use a Network facility:** Covered at 80% of the Plan's schedule after the following per confinement copayments:  
\$20 - Plan A  
\$10 - Plans 4, B, 3 and C.

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# Hospital Outpatient Coverage

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## SUMMARY

Coverage Provided for:

- Emergency Treatment
- Surgery

### *In Network*

covered at 100%,  
of the network rate after  
any applicable copayment

### *Out-of-Network:*

covered at 80% of  
the Plan's schedule after any  
applicable copayment

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## Emergency Treatment<sup>8</sup>

**For eligible participants of Plans A, 4, B, 3, and C:**

Coverage is provided for charges for the use of the emergency room facilities and other services and supplies billed by the hospital.

Coverage is provided for emergency treatment within 24 hours of an accident as follows:

- **If you use a Network hospital:** Covered at 100% of the network rate, subject to the following copayments:  
\$20 - Plan A  
\$10 - Plans 4, B, 3 and C.
- **If you do not use a Network hospital:** Covered at 80% of the Plan's schedule, subject to the following copayments:  
\$20 - Plan A  
\$10 - Plans 4, B, 3 and C.

Coverage is provided for emergency treatment within 24 hours of a sudden and serious illness as follows:

- **If you use a Network hospital:** Covered at 100% of the network rate after a \$100 copayment per visit.
- **If you do not use a Network hospital:** Covered at 80% of the Plan's schedule after a \$100 copayment per visit.

For Plan A only:

Coverage for **non** sudden and serious illness treatment is provided on the following basis:

- **If you use a Network hospital:** Covered at 100% of the network rate up to a family maximum benefit of \$200, subject to a \$100 copayment per visit. This includes physician services.
- **If you do not use a Network hospital:** not covered.

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<sup>8</sup>A true emergency is the sudden and unexpected onset of a serious condition or illness for which treatment cannot be delayed without the risk of losing your life or seriously or permanently impairing your health. For example, if you go the emergency room as a result of cardiac pain, massive bleeding, poisoning, shock, severe or multiple injuries of a stroke, treatment will be covered. If you go to the emergency room with a condition that could be treated in a doctor's office, the hospital outpatient non-emergency visit benefit will be applicable.

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## Surgery

Coverage is provided for use of the operating room facilities of the hospital for a surgical operation as follows:

- **If you use a Network hospital:** Covered at 100% of the network rate.
- **If you do *not* use a Network hospital:** Covered at 80% of the Plan's schedule.

Professional fees which are not billed by the hospital (that is, charges that do not appear on the hospital bill), are not covered under Hospital Outpatient Coverage.

# Major Medical Coverage

## SUMMARY

### Major Medical Coverage

- *Calendar year deductible;*
- *Lifetime maximum payment per illness*

### Coverage for:

- surgery / assistant surgeon
- maternity
- removal of impacted wisdom teeth
- second surgical opinion
- anesthesia
- physician charges
- well child care
- well care / immunizations
- annual physical exam
- chiropractic visits
- allergy treatment
- x-ray, laboratory & diagnostic testing
- physical therapy
- psychotherapy
- substance abuse therapy
- air ambulance
- medical supplies
- private duty nursing
- dental care for accidental injury
- special services benefits

## Calendar Year Deductible (Per Person)

HOW THE PLAN WORKS: When the total eligible expenses incurred in a calendar year by a participant or dependent exceed the "Deductible" (where applicable) described below, the Plan will pay benefits as described in this booklet up to the lifetime maximum per injury or illness of \$25,000 (\$75,000 for Plan A). The deductibles are as follows:

	Plan "A"	Plan "4", "B"	Plan "3", "C"*
In-Network deductible	\$0	\$0	\$300
Out-of Network deductible	\$150	\$200	\$300

\*Plan C deductible applies to in and out of network benefits.

The deductible applies only ONCE IN A CALENDAR YEAR, even if the covered individual has several different non-occupational accidents and/or sicknesses in the same calendar year. A new deductible must be satisfied by the individual each calendar year before Major Medical Benefits are paid in that year. The deductible for a calendar year must be made up of expenses incurred during that year.

## Surgery<sup>9</sup>

**Benefits for eligible participants, dependents and participants who are retired only.** If any surgery is planned for you, whether or not a hospitalization is planned, you must notify Alicare Medical Management. Failure to call will result in a reduction in coverage (see "Medical Certification Program").

You must receive prior authorization from the Plan Office for any elective surgery performed outside the tri-state area. Failure to do so will result in a denial of benefits.

In addition, the Plan provides coverage for breast reconstruction in connection with a mastectomy. Breast reconstruction may be selected in a manner determined by you or a covered dependent in consultation with your attending physicians, and the plan will provide benefits as follows:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce symmetrical appearance: and

<sup>9</sup>If multiple surgical procedures are performed during one operative session, the primary procedure is covered according to the surgical schedule, and the other procedures are covered at 50% of the scheduled amount.

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- coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas.

### **Assistant Surgeon**

The Plan also provides coverage for the charges of an assistant surgeon when it is determined to be medically necessary, according to a fixed schedule of charges for assistant surgery. This benefit is paid only to a licensed Physician.

Coverage for **Surgery** and the services of an **Assistant Surgeon**, is provided on the following basis:

- **If you use a Network provider:** Plan A-covered at 100% of the network rate.  
Plans B, 4, 3, and C-covered at 80% of the network rate, subject to any applicable deductible.
- **If you do not use a Network provider:** Covered at 80% of the Plan's schedule, subject to the calendar year deductible.

### **Maternity**

Maternity related charges are payable to a physician or certified nurse midwife in accordance with the surgical schedule.

Coverage for **Maternity** is provided on the following basis:

- **If you use a Network provider:** Plan A-covered at 100% of the network rate.  
Plans 4 and B-covered at 80% of the network rate up to a maximum benefit of \$1,500.  
Plans 3 and C-covered at 80% of the network rate up to a maximum benefit of \$1,000.
- **If you do not use a Network provider:** Plan A-covered at 80% of the Plan's schedule up to a maximum benefit of \$3,200, subject to the calendar year deductible.  
Plans 4 and B-covered at 80% of the Plan's schedule up to a maximum benefit of \$1,500, subject to the calendar year deductible.  
Plans 3 and C-covered at 80% of the Plan's schedule up to a maximum benefit of \$1,000, subject to the calendar year deductible.

Maternity Benefits for eligible participants and spouses- expenses including pre-natal & post-partum care are covered for all types of delivery.

Elective Termination of Pregnancy is covered for Plans A, B and C as in-network only. Dependent children are not covered for this benefit.

### **No Surgical/Maternity Expense Benefits Are Provided For:**

- Cosmetic surgery.
- Maternity Benefits for dependent children.
- Laser Eye (Lasik) Surgery.

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## Removal Of Impacted Wisdom Teeth

Coverage is provided for the surgical removal of impacted wisdom teeth as follows:

- **If you use a Network provider:** Plan A-covered at 100% of the network rate.  
Plans B, 4, 3, and C-covered at 80% of the network rate, subject to any applicable deductible.
- **If you do not use a Network provider:** Covered at 80% of the Plan's schedule, subject to the calendar year deductible.

## Second Surgical Opinion

Coverage for Plan "A" Participants only. Benefits will be payable for any Voluntary Second Surgical Opinion as follows:

- **If you use a Network provider:** Covered at 100% of the network rate up to a maximum benefit of \$300.
- **If you do not use a Network provider:** Covered at 80% of the Plan's schedule up to a \$300 maximum payment.

If a second opinion states that the proposed surgery is not medically advisable, a third opinion will be covered in the same manner as the second opinion.

## Anesthesiology

**Anesthesia benefits for eligible participants, dependents and participants who are retired only.** If you or an eligible dependent undergoes an operation for which surgical benefits are payable, you will receive a benefit for anesthesia charges incurred. This benefit is paid only if the anesthesia is administered by a medical doctor other than the operating surgeon or a paid employee of the hospital. The Anesthesia Benefit payable is payable as follows:

- **If you use a Network provider:** Plan A-covered at 100% of the network rate.  
Plans 4 and B-covered at 80% of the network rate.  
Plans 3 and C-covered at 80% of the network rate, subject to the calendar year deductible.
- **If you do not use a Network provider:** Plan A-covered at 80% of the Plan's schedule payable at 30%, subject to the calendar year deductible.  
Plans 4, B, 3 and C-covered at 80% of the Plan's schedule payable at 24%, subject to the calendar year deductible.

You may be eligible for an enhanced payment if you use a network facility and a network surgeon. If you meet this 2 out of 3 rule, your out of network anesthesia benefit will be paid as follows:

- Plan A: 100% of the Plan's schedule payable at 30%, not subject to the deductible.
- Plans 4, B, 3 and C: 100% of the Plan's schedule payable at 24%, not subject to the deductible.

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## Physician Charges

Medical Expense Benefits are provided for eligible participants and their dependents and pensioners for home, office, and hospital visits by a legally qualified physician, for any non-occupational disability.

No Medical Expenses Benefits will be paid for treatments on or after the day of an operation for which Surgical Expense Benefits are paid, unless medical treatments are for an injury or disease, which is entirely unrelated to the disability for which surgery was performed.

Physician charges for surgery are covered under Surgical Coverage.

**Physician Hospital Inpatient, Home and Office Visits** are covered as follows:

- **If you use a Network provider:** Plan A-covered to \$1,500 maximum payment per calendar year in and out of network; \$20 copayment per visit, then 100% of the network rate.  
Plans 4 and B-covered to \$750 maximum payment per calendar year in and out of network; \$10 copayment per visit, then 80% of the network rate.  
Plans 3 and C-\$10 copayment per visit, then 80% of the network rate, subject to the calendar year deductible.
- **If you do not use a Network provider:** Plan A-covered to \$1,500 maximum payment per calendar year in and out of network; \$35 Basic benefit, then 80% of the Plan's schedule, subject to the \$20 copayment and the deductible.  
Plans 4 and B-covered to \$750 maximum payment per calendar year in and out of network; \$20 Basic benefit, then 80% of the Plan's schedule, subject to the \$10 copayment and the deductible.  
Plans 3 and C-\$10 copayment per visit, then 80% of the Plan's schedule, subject to the calendar year deductible.

## Physician Emergency Room Visits

Coverage is provided for emergency treatment by a physician within 24 hours of an accident of a sudden and serious illness as follows:

- **If you use a Network provider:** Plan A-covered at 100% of the network rate, subject to the \$20 copayment per visit.  
Plans 4, B, 3 and C-covered at 100% of the network rate subject to the \$10 copayment per visit and any applicable deductible.
- **If you do not use a Network provider:** Plan A-covered at 80% of the Plan's schedule, subject to \$20 copayment per visit and the calendar year deductible. However, if the facility is in network, the copayment and deductible are waived.  
Plans 4, B, 3, and C-covered at 80% of the Plan's schedule, subject to \$10 copayment per visit and the calendar year deductible. However, if the facility is in network, the copayment and deductible are waived.

**For Plan A only:** Coverage for non sudden and serious illness treatment is provided on the following basis:

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- **If you use a Network provider:** Covered at 100% of the network rate up to a family maximum benefit of \$200, subject to a \$100 copayment per visit. This includes emergency room facility charges.
  - **If you do *not* use a Network provider:** Not covered.

## Well Child Care

**For Plan A dependents only:** Routine physical exams and immunizations for dependents up to the 5th birthday for up to five visits per calendar year, are covered as follows, provided immunizations are given during a well care visit.

- **If you use a Network provider:** Covered at 100% of the network rate, after a \$20 copayment per visit.
- **If you do *not* use a Network provider:** \$20 copayment per visit, then 80% of the Plan's schedule for up to \$40 maximum payment per visit.

## Well Care/Immunizations

**For Plan A dependents only:** Coverage is provided for dependents from the age of 5-18 (19-24 for full time students) for one well care visit each year as follows, provided immunizations are given during a well care visit.

- **If you use a Network provider:** Covered at 100% of the network rate, after a \$20 copayment per visit.
- **If you do *not* use a Network provider:** \$20 copayment per visit, then 80% of the Plan's schedule for up to \$40 maximum payment per visit.

## Flu Shots

**For Plan A, B, 4, 3 and C:** Coverage is provided as follows:

- **If you use a Network provider:** Covered at 100% of the network rate.
- **If you do *not* use a Network provider:** Covered at 100% of the Plan's schedule, subject to the deductible.

## Annual Physical Exam

**For Plan A participants & spouses; Plans B and 4 participants only:** Coverage is provided at 100% of the network rate up to \$300, toward the cost of a diagnostic physical examination and gynecological examination including diagnostic x-ray and laboratory tests once each year

The Plan has made arrangements with a health care center, Professional Medical Evaluation Group (516-935-4378) to provide the above examination for eligible participants with no out-of-pocket expense. Call the Plan office for additional information.

## Chiropractic Visits

**For Plan A participants & dependents only:** Coverage is provided for up to \$20 per visit for up to 20 chiropractic visits per person per calendar year.

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## Allergy Treatment

Coverage is provided for allergy treatment as follows:

- **If you use a Network provider:** Plan A-covered at 100% of the network rate up to a \$600 maximum payment per calendar year combined in and out of network.  
Plan B-covered at 100% of the network rate up to a \$100 maximum payment per calendar year combined in and out of network.
- **If you do *not* use a Network provider:** Plan A-covered at 100% of the Plan's schedule, up to a \$600 maximum payment per calendar year combined in and out of network.  
Plan B-covered at 80% of the Plan's schedule, up to a \$100 maximum payment per calendar year combined in and out of network.

Plans C and 3 do not have coverage for allergy treatment.

## X-ray, Laboratory, and Diagnostic Testing<sup>10</sup>

**For eligible Participants, Dependents and Participants who are retired:**

If you have an x-ray or laboratory examination by or at the request of a legally qualified medical doctor, or surgeon, you will receive benefits for any one examination or for all x-ray and laboratory examinations made during any one calendar year as indicated in your Plan's schedule of benefits. This benefit will be paid only in connection with x-ray and laboratory procedures not requiring hospital confinement and is in addition to any tests received while the patient is confined in a hospital. The X-Ray & Laboratory benefits will be payable as follows:

### Laboratory

- **If you use a Network provider:**  
Plan A-covered at 100% of the network rate.  
Plans 4 and B-covered at 100% of the network rate up to a maximum benefit of \$400 per calendar year, then 80% of the network rate.  
Plans 3 and C-covered at 100% of the network rate up to a maximum benefit of \$150 per calendar year, subject to the calendar year deductible, then 80% of the network rate.

Plans 4, B, 3 and C: Network and non-network calendar year benefits are combined toward the maximum.

- **If you do *not* use a Network provider:**  
Plan A-covered at 100% of the Plan's schedule up to a maximum benefit of \$700 per calendar year, subject to the calendar year deductible and \$20 copayment.  
Plans 4 and B-covered at 100% of the Plan's schedule up to a maximum benefit of \$400 per calendar year, subject to the calendar year deductible and \$10 copayment.  
Plans 3 and C-covered at 100% of the Plan's schedule up to a maximum benefit of \$150 per calendar year, subject to the calendar year deductible and \$10 copayment.

<sup>10</sup>This coverage applies where charges are billed separately from a hospital bill. Where the charges are part of a hospital bill, they are covered as part of the Plan's Hospital Inpatient or Outpatient coverage.

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## X-Ray And Diagnostic Testing

- **If you use a Network provider:**  
Plan A-covered at 100% of the network rate subject to \$20 copayment.  
Plans 4 and B-covered at 100% of the network rate up to a maximum benefit of \$400 per calendar year, subject to \$10 copayment, then 80% of the network rate.  
Plans 3 and C-covered at 100% of the network rate up to a maximum benefit of \$150 per calendar year, subject to the calendar year deductible and \$10 copayment, then 80% of the network rate.

Plans 4, B, 3 and C: Network and non-network calendar year benefits are combined toward the maximum.

- **If you do *not* use a Network provider:**  
Plan A-covered at 100% of the Plan's schedule up to a maximum benefit of \$700 per calendar year, subject to the calendar year deductible and \$20 copayment.  
Plans 4 and B-covered at 100% of the Plan's schedule up to a maximum benefit of \$400 per calendar year, subject to the calendar year deductible and \$10 copayment.  
Plans 3 and C-covered at 100% of the Plan's schedule up to a maximum benefit of \$150 per calendar year, subject to the calendar year deductible and \$10 copayment.

Plans 4, B, 3, and C: Once the combined network and non-network maximum is reached for x-ray, laboratory and diagnostic testing benefits, there are further benefits available under Major Medical Coverage for network services only.

NO BENEFIT will be paid if the x-ray or laboratory examination is in connection with the following:

- Dental work.
- Eye examinations.

## Physical Therapy (Outpatient Only)

Coverage is provided for outpatient treatment by a licensed physical therapist. Coverage will be reviewed for necessity after 30 visits in one year. Coverage is provided as follows:

- **If you use a Network provider:** Plan A-covered at 100% of the network rate.  
Plans 4 and B-covered at 80% of the network rate.  
Plans 3 and C-covered at 80% of the network rate, subject to the calendar year deductible.

**Plan "A" only:**

- **If you do *not* use a Network provider:** Covered at 80% of the Plan's schedule, subject to the calendar year deductible.

**No out of network benefit is available for Plans 4, B, 3 and C.**

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## **Psychotherapy (For Plans A, 4, B, 3 & C)**

### **For eligible Participants, Dependents only**

The regular Major Medical Benefits apply to expenses incurred during a hospital stay for which room and board charge is made, and to the charges for administration of convulsive therapy whether administered in or out of a hospital. For inpatient and outpatient services, benefits are as follows:

#### **InPatient:**

- **If you use a Network provider:** Plan A-covered at 100% of the network rate subject to \$20 copayment.  
Plans 4, B, 3, and C-covered at 80% of the network rate subject to \$10 copayment and applicable deductible.
- **If you do *not* use a Network provider:** Covered up to a maximum payment of \$40 per visit.

#### **OutPatient:**

- **If you use a Network provider:** Plan A-covered up to a maximum payment of \$40 per visit after a \$20 copayment per visit for up to 50 visits per person per calendar year, combined in and out of network.  
Plans 4, B, 3, and C-covered up to a maximum payment of \$40 per visit after a \$10 copayment per visit for up to 50 visits per person per calendar year, combined in and out of network.
- **If you do *not* use a Network provider:** Plan A-covered up to a maximum payment of \$40 per visit after a \$20 copayment per visit for up to 50 visits per person per calendar year, combined in and out of network.  
Plans 4, B, 3, and C-covered up to a maximum payment of \$40 per visit after a \$10 copayment per visit for up to 50 visits per person per calendar year, combined in and out of network.

Full confidentiality of all records regarding these claims is assured.

## **Outpatient Substance Abuse Therapy**

### **(For Plan A Journeymen who have made 60 months of contributions & their dependents only)**

Coverage is provided for treatment of substance abuse to \$15,000 in-network or \$12,000 per family out-of-network, lifetime maximum payment, as follows:

- **If you use a Network provider:** Covered at 100% of the network rate.
- **If you do *not* use a Network provider:** Covered at 80% of the network rate, subject to the calendar year deductible.

## **Air Ambulance Services**

Fees for air ambulance transport in life or death situations will be covered under the Plan, subject to medical necessity and Plan maximums.

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## Medical Supplies

Coverage is provided for the purchase of the following medical supplies: artificial limbs and eyes, surgical dressings, casts, splints, trusses and braces. Coverage is provided as follows:

- **If you use a Network provider:** Covered at 100% of the network rate.
- **If you do *not* use a Network provider:** Covered at 80% of the Plan's schedule, subject to the calendar year deductible.

## Private Duty Nursing

Coverage is provided for private duty nursing services by a registered graduate nurse (R.N.) or licensed practical nurse (L.P.N.)

- **If you use a Network provider:** Covered at 100% of the network rate.
- **If you do *not* use a Network provider:** Covered at 80% of the Plan's schedule, subject to the calendar year deductible.

## Dental Treatment for Accidental Injury to Natural Teeth

Coverage is provided for dental treatment due to the accidental injury to natural teeth. Includes coverage for oral surgery if needed as a part of a larger service for treatment of an underlying medical condition, full or partial dentures, fixed bridgework, prompt repair to natural teeth, crowns, etc., as follows:

- **If you use a Network provider:** Covered at 100% of the network rate.
- **If you do *not* use a Network provider:** Covered at 80% of the Plan's schedule, not subject to the deductible.

## Special Service Benefits (For Plan A Participants, Dependents & Participants who are retired; For Plans B & 4 Participants only)

Coverage is provided at 100% of the network rate for up to a \$1,300 maximum payment per person per calendar year, in and out of network combined, for the following:

- blood and its transfusion
- ambulance service
- oxygen
- rental of crutches
- rental of a wheel chair
- rental of a hospital bed at home
- therapeutic devices and appliances such as orthopedic shoes, support garments, etc.

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# How The Plan Works With Other Coverage

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## **Coordination Of Benefits (COB):**

1. This Plan has been designed to help you meet the cost of illness or injury. Since it is not intended that you receive greater benefits than the actual medical expenses incurred, the amount of benefits payable under this Plan will take into account any coverage you may have under other Plans; that is the benefits under this Plan will be coordinated with the benefits of the other plans. It is not the intent of this Plan that any Participant receives greater benefits than the actual medical expenses incurred. It would be unfair to the other Participants and would reduce benefits the Plan can provide for all coverage.

2. "Plan" means any plan providing benefits or service for which benefits are provided by:

(a) Group or blanket insurance coverage,

(b) Group hospital or medical service plans, and other group payment coverage,

(c) Any group coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans,

(d) Any group or blanket coverage by or provided through a school or other educational institution,

(e) Any other plans,

(f) Any coverage provided by No Fault Insurance Laws.

3. "Allowable Expenses" means any necessary, reasonable and customary expense incurred while eligible for benefits under this plan, part or all of which would be payable under any of the plans coordinated with this plan. In coordinating benefits, one of the two or more plans involved is the primary plan and the other plans are secondary plans.

The primary plan pays benefits first without consideration of the other plans. The secondary plans then make up the difference up to the total "Allowable Expenses." No plan will pay more than it would have paid without this special provision. If one plan has no coordination of benefits provision, it is automatically the primary plan.

## **Order Of Benefit Determination And Exclusion:**

1. The Insurance Plan assumes primary responsibility for your spouse and/or children if your spouse and/or children are not

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separately covered by a Plan. If your spouse and/or children are separately covered by a Plan, the Insurance Plan will assume secondary responsibility, and will pay any balance not paid by said Plan, subject to the limits of our Insurance Plan schedules.

2. If a dependent child is the patient and is covered under both parents' plans, then the plan covering the parent whose birthday is earlier in the year is primary. "Birthday" shall mean the month and day of birth and not the year of birth. This rule will apply if both plans being coordinated have the "Birthday Rule" and the other has a "Gender Rule" the Plan with the "Gender Rule" will prevail in determining coverage. However, if the parents are separated or divorced, benefits will be determined as follows:

a. If the parent with custody of the child has not remarried, then the contract of the parent with custody is primary.

b. If the parent with custody of the child has remarried, the contract of the parent with custody is primary. Also, the benefits of the step-parent will be determined before the contract of the parent without custody.

c. However, if it has been established by a court decree that one parent has financial responsibility for the child's health care expenses, then the contract of that parent is primary.

d. Where the husband and wife are both covered under separate Plans, the first application for benefits must be made to the Plan, which has primary responsibility. Therefore, the spouse of one of our participants should apply to his or her own plan. If that Plan does not cover all the expenses incurred, then our Plan will pay any balances not paid by the Plan, subject to the limits of our Insurance Plan Schedules.

e. For the participants who are covered by the Insurance Plan and maintain individual Plans, our Insurance Plan will have secondary responsibility. Therefore, after payment is made by the individual Plan, the Insurance Plan will pay any balances not paid by the other Plan, subject to the limits of our Insurance Plan Schedules.

f. For a participant who is covered by more than one Plan other than an individual Plan as stated in paragraph (d) above, the order of benefit determination will be determined by assigning "primary responsibility" to the Plan which has covered the individual the longest.

Any Plan as related to this section will be deemed to include no-fault Insurance, Auto Insurance, or similar insurance that provides benefits. Benefits will not be provided by this Plan if a participant, spouse or dependent would be covered under any no-fault Insurance Law but is lawfully excluded from such coverage due to any of the following reasons:

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1. Intentionally causes his/her own injury;
  2. Is injured as a result of operating a motor vehicle while in an intoxicated condition or while his ability to operate such vehicle is impaired by the use of a drug; or...
  3. Is injured while he/she is...
    - (a) Committing an act under which would constitute a felony, or seeking to avoid lawful apprehension, or arrest by a law enforcement office, or...
    - (b) Operating a motor vehicle in a race or speed test, or..
    - (c) Operating or occupying a motor vehicle known to him to be stolen, or if any person shall not be covered by no-fault Insurance because of a failure to maintain such insurance coverage, benefits will not be provided by this Plan.

INFORMATION NECESSARY TO THE ADMINISTRATION OF THE COORDINATION OF BENEFITS PROVISION WILL BE REQUIRED AT THE TIME A CLAIM IS SUBMITTED:

If you have any doubt about coverage for you, your spouse and/or children, please get in touch with the Plan office.

We will be glad to make sure that you receive all benefits to which you are entitled.

## **Medicare Coverage**

Medicare is the federal government's health insurance program for individuals age 65 and older. Individuals under age 65 who are disabled may also be entitled to Medicare.

If you are working in covered employment for an employer with 20 or more employees, and you are entitled to Medicare, the Plan will provide its full health care coverage first and Medicare will pay second. If you are working in covered employment for an employer with fewer than 20 employees, Medicare will provide coverage first and the Plan will pay second.

Federal law requires that you have the right to elect to cancel your Plan health care coverage and have Medicare as your primary insurer. **If you make this election, all your Plan health care coverage will be canceled and you will have substantially less coverage.** This election is applicable only while you are age 65 or older and continue to work in covered employment. It does not affect your Death Benefits. Your covered spouse also has a separate right to elect to cancel Plan coverage provided he or she is age 65 or older and you contin-

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ue to work in covered employment. Any such election must be made in writing to the Plan Office.

### **Automobile No-Fault Coverage**

If your injury is caused by an accident in a state that is covered by an automobile no-fault insurance law or similar law relating to motor vehicle coverage and financial responsibility when not entitled a “No-fault” law, the automobile no-fault insurance is responsible for paying the covered charges for that injury first. The Plan will then cover the balance of the covered charges that were not covered by the automobile no-fault insurance up to the limits of its coverage.

### **Liability Coverage (Subrogation)**

When benefits are paid or payable to or for an employee or a dependent under the terms of this Plan, the Plan shall be subrogated to the rights of recovery of such employee or dependent against any person or entity who is liable for the injury that necessitated the hospitalization or the medical or the surgical treatment for which the benefits were paid. Such subrogation rights shall extend only to the recovery by the Plan of the benefits it has paid for such hospitalization and medical treatment, and the Plan shall pay its share of fees and costs associated with such recovery.

If the Plan requests information from the claimant regarding material necessary for the implementation of this subrogation provision with respect to a claim, the Plan reserves the right to withhold payment of such claim pending the submission of the requested information.

### **Workers’ Compensation Coverage**

The Plan does not cover any charges for health care for which there is entitlement to Workers’ Compensation. Workers’ Compensation is a state administered program which offers coverage for health care costs and loss of earnings resulting from an occupationally related disease or accident.

Additional information about Workers’ Compensation can be obtained from the State Workers’ Compensation Board.

### **Government Coverage**

If health care coverage is available for any condition or treatment covered by a government program (such as through a state hospital), or pursuant to any federal, state or municipal law, coverage under the Plan will not be provided. Except as provided elsewhere herein, Medicare shall not be deemed to be such a government program.

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# Special Program Of Benefits for Participants Who Are Eligible For Medicare Supplement

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**(Dependents are not covered under the special program)**

This Special Program of Benefits is designed to provide every participant who is retired who is eligible for Medicare as a primary carrier with greater benefits than it is possible to provide for persons under age 65, because part of the cost of the additional benefits will be paid by Medicare.

THIS PROGRAM IS NOT APPLICABLE TO WORKING PARTICIPANTS AND THEIR SPOUSES; UNDER THESE CIRCUMSTANCES THE BENEFITS PROVIDED FOR PARTICIPANTS WHO ARE UNDER AGE 65 WILL BE APPLICABLE AND MEDICARE WILL BE THE SECONDARY CARRIER AFTER THE PLAN HAS PAID BENEFITS AS THE PRIMARY CARRIER.

## **Procedure For Filing Claims For Medicare Medical Benefits:**

- Telephone or write the Plan office for proper claim forms. Medicare Form 1490 may be obtained from any physician. Complete and sign both the Insurance Plan claim form and Medicare Form 1490.
- Attending physicians must complete and sign the Insurance Plan claim form.
- Send the completed Insurance Plan claim form and the bill from the attending physician listing his charges and diagnosis to the Plan office.
- As soon as you receive notification from the Medicare carrier send the notification to the Plan office.
- Additional benefits that you may be entitled to will then be paid by the Insurance Plan.

## **Hospital Benefits For Participants Who Are Retired And Are Eligible For Medicare:**

Since Medicare does not pay the Medicare hospital deductible for each admission to a hospital, the Insurance Plan will reimburse you for the charge. All you have to do is send the Plan a copy of the hospital bill and Medicare Explanation of Benefits (EOB). If you wish, the Plan will make payment directly to the hospital on the basis of your assignment.

The combination of the benefit from both the Unions' Insurance Plan and Medicare will take care of your hospital cost for the first 60 days. If your regular benefit program provides more than 60 days of hospital coverage, you will be entitled to the additional hospital benefits

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from the Plan described in this benefit booklet, which will be coordinated with the benefits provided by Medicare.

**All Other Medicare Benefits:**

As a general rule, Medicare will pay 80% of these benefits, after the satisfaction of the Medicare deductible. It is the intent of this Plan to pay both the Medicare deductible and the 20% not paid by Medicare but the amount paid by this Plan for any single benefit cannot exceed the amount which would normally be paid for the same benefit rendered to a covered person who is not eligible for Medicare.

**Prescription Drug Benefits, Optical Expense Benefits, And Dental Care Benefits:**

The Plan will continue to cover an eligible participant who is retired and over the age of 65 for Prescription Drugs, Dental Care, or Optical (Dependents of the eligible participant who is retired and over the age of 65 are not covered under the special program).

**Death Benefits For Participants Who Are Retired:**

Since Medicare does not provide Death Benefits, the Insurance Plan will continue to pay these benefits as indicated.

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# How To File A Health Care Claim

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## NOTIFICATION AND FILING TIME FOR ALL CLAIMS:

Written notice of any injury or sickness should be given to both the Plan Office and your Employer within 30 days after the date on which the injury or illness occurs. Failure to do so may result in the potential loss of entitlement to state sponsored Disability or Workman's Compensation benefits. Proof of such injury or illness (A COMPLETE ITEMIZED CLAIM FORM WITH DOCTOR'S LIST OF SERVICES RENDERED) must be received within 12 months of the injury or sickness. Claims received after 12 months will be denied.

A health benefit identification card is issued to you when you first become covered. Use this card when you visit any health care provider.

All claims, except for those submitted electronically, must be submitted in writing to the address set forth on the back of your identification card and must include the participant name, social security number and the patient name. They must also be signed by the patient or authorized representative. Most providers will submit their standard computerized form or submit their claim electronically. If you are the one filing a claim you must obtain an appropriate claim form. The appropriate claim form is available from the Plan office.

In order to appoint an authorized representative the patient must complete and return an Authorization for Release of Information-Appointment of Authorized Representative form that can be obtained from the Plan office.

The Plan office or its Benefits Administrator makes all decisions about eligibility and claims. Payment will be made to the facility or health care provider unless receipts are submitted showing that the bill has already been paid, in which case payment will be made directly to the patient or legal guardian. Adverse claims decisions may be appealed (see "Your Right to Appeal").

## What Is A Claim?

A claim is a request for benefits submitted in accordance with Plan rules.

## Claim Type Definitions

There are several categories of claims:

**Urgent Care Claim** - An urgent care claim is any claim for medical care or treatment with respect to which, lack of immediate processing of the claim could seriously jeopardize the life or health of you or your insured dependent or, in the opinion of the treating physician with knowledge of the medical condition, would subject you or your Dependent to severe

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pain that cannot be adequately managed without the care or treatment that is the subject of the claim. This type of claim generally includes those situations commonly treated as emergencies.

**Pre-Service Care Claim** - A pre-service care claim is a claim for a benefit under the Plan with respect to which the terms of the Plan require approval (usually referred to as pre-certification) of the benefit in advance of obtaining medical care.

**Post-Service Care Claim** - A post-service care claim is a claim for a benefit under the Plan that is not a pre-service claim. It involves the submission of bills by the patient or its authorized representative for care or services already rendered. An itemized bill forwarded by the provider who has a right to balance bill (for charges other than co-insurance and deductibles) is considered to be a claim for benefits.

**Concurrent Care Claim** - A concurrent care claim is a claim for an extension of the duration or number of treatments provided through a previously approved benefit claim. Where possible, this type of claim should be filed at least twenty-four (24) hours before the expiration of any course of treatment for which an extension is being sought.

Under the Plan, a claim for benefits means a request for a Plan benefit or benefits made by you or your authorized representative in accordance with the following claims procedures. Simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim will not be treated as a claim for benefits. Your interactions with participating providers, panel providers, pharmacists or any other health care provider under the Plan will not be treated as a claim for benefits. In addition, a request for a prior approval of a benefit that does not require prior approval by the Plan or an inquiry about Plan eligibility is not a claim for benefits. You must file a claim for benefits in accordance with the claims procedures listed below in order to appeal a claim under the Plan.

You may file any claim yourself, or you may designate another person as your "authorized representative" by notifying the Plan Administrator in writing of that person's designation. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an urgent care claim. If an authorized representative is designated, any subsequent communication will be made consistent with that authorization.

You may file any claim for benefits, including ones for concurrent care, pre-service care, or post-service care, yourself or through your authorized representative. Any of these types of claims must be filed using a written form supplied by the Plan Administrator and may be submitted by U.S. Mail, by hand delivery or by facsimile.

If your claim involves urgent care, you may initiate a claim for urgent care benefits yourself if you are able, or your treating physician may file

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the claim for you. The claim may be made by telephone, or by U.S. Mail, by hand delivery or by facsimile. If your claim is filed by telephone, you will be responsible for completing any follow-up paperwork the Plan may require in support of your claim.

The Plan Administrator provides forms for filing those claims and authorized representative designations under the Plan that must be filed in writing.

### **Determination of Benefits**

The Benefits Administrator has authority to determine the amount of benefits that will be paid on any particular benefit claim. In making benefit determinations, the Benefits Administrator has the complete discretion and authority to make factual findings regarding a claim and to interpret the terms of the Plan as they apply to the claim. In any case, you will receive only those benefits under the Plan that the Benefits Administrator determines you are entitled to receive.

### **Timeframes for Notification of Initial Benefit Determination**

**Urgent Care Claim** - you or your authorized representative will be notified of the Plan's initial decision on the claim, whether adverse or not, as soon as possible, but in no event more than seventy-two (72) hours after the Plan has received the claim. If the claim does not include sufficient information for the Benefits Administrator to make an intelligent decision or you have failed to follow the Plan's claim procedures, you or your representative will be notified within twenty-four (24) hours after receipt of the claim of the need to provide additional information. You will also receive a copy of the proper procedures to be followed. You will have at least forty-eight (48) hours to respond to this request. The Benefits Administrator must inform you of its decision as soon as possible, but in no case later than forty-eight (48) hours after the earlier of (i) receiving the additional information or (ii) the end of the period you had to provide the specified information.

**Concurrent Care Claim** - you or your authorized representative will be notified of the Plan's decision at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. If the claim to extend the course of treatment or the number of treatments involves urgent care, the Plan will notify you, whether adverse or not, within twenty-four (24) hours after receiving the claim provided that the claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or the number of treatments. You will be given time to provide any additional information required to reach a decision.

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Pre-Service Care Claim - you or your authorized representative will be notified of the Plan's initial decision on the claim, whether adverse or not, as soon as possible, but not more than fifteen (15) days from the date the Plan receives the claim. This 15-day period may be extended by the Plan for an additional fifteen (15) days if the extension is required due to matters beyond the Plan's control. If such an extension is necessary, you will receive written notice of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision prior to the expiration of the 15-day period. If the extension is necessary due to your failure to submit the information necessary to decide the claim or your failure to follow the Plan's claim procedures, you will receive a notice that specifically describes the required information or the proper procedures to be followed. You will receive notification of your failure to follow the Plan's claim procedures not later than five (5) days after your claim is filed. You will have at least forty-five (45) days to provide to the Plan any additional information requested of you. In the event that a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination will 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.

Post-Service Care Claim - you or your authorized representative will be notified of the Plan's decision on the claim, only if it is denied in whole or in part. This notification will be issued no later than thirty (30) days after the Plan receives the claim. The Plan may extend this 30-day period one time for up to fifteen (15) days if the extension is required due to matters beyond the Plan's control and if the Plan 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 Plan expects to render a decision. If such an extension is necessary due to your failure 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 forty-five (45) days to provide to the Plan any additional information requested of you. In the event that a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination will 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.

### **Manner and Content of Notification of Initial Benefit Determination**

If your claim for benefits has been denied, in whole or in part, you will be provided with adequate notice in writing setting forth:

- the specific reason(s) for such denial with references to the specific plan provisions on which the denial is based;

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- a description of any additional material or information necessary for you to perfect the claim (including an explanation as to why such information is necessary);
  - a description of the review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;
  - that if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, you will receive 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, upon request; and
  - that if the benefit determination is based upon 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 your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

In the case of an adverse benefit determination concerning a claim involving urgent care, you will also receive a description of the expedited review process applicable to such claim. In addition, if your claim involves urgent care, the information described in the first three items above may be provided orally, provided that a written or electronic notification is furnished to you not later than three (3) days after the oral notification.

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# Your COBRA Rights

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## Direct Payment Plan (COBRA):

This Federally mandated plan is required to provide continuation of health care benefits for all participants and their dependents that have had their eligibility for benefits terminated. At the time of a “qualifying event” you and/or your covered dependents will be notified of this opportunity to continue medical coverage provided by this Plan.

Under this provision you and/or your covered dependent(s) have the opportunity to pay for the continuation of your group health medical coverage which would otherwise end as a result of any of the following “qualifying events:”

- Your termination of employment. **(Except for gross misconduct.)**
- A reduction of your hours so that you or your dependent (s) no longer meet the eligibility requirements for coverage.
- In the event of your death.
- In the event that you take a leave of absence.
- In the event of your divorce or legal separation.
- Your child no longer qualifies as a dependent.

If you or your covered dependent(s) elect to continue core health coverage, which would exclude the death benefit and weekly accident and disability benefits, coverage would be extended as follows:

- Up to 18 months in the event of your termination of employment or a reduction in your hours,
- Up to 29 months in the event you receive a Social Security Disability Award within the first 18 month period of continuation coverage.
- Up to 36 months for your dependent(s) in the event of your death, divorce, or legal separation, or child no longer qualifies as dependent.

You and/or your spouse will then have 60 days in which to elect continuation of coverage. This election period will end:

- 60 days from the “qualifying event” or,
- 60 days from the date we notify you of your continuation rights. An election by a parent for continued coverage would include dependent children. If you do not choose continuation of coverage, your coverage provided by the plan will end. If you opt for continuation of coverage, you have 60 days in which to make the initial payment.

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A newborn infant of, or a newly adopted child placed with a participant already on COBRA receiving single coverage will be entitled to obtain COBRA continuation coverage as a qualified beneficiary of the participant provided:

- The participant informs the plan of the birth of such newborn infant or adoption of such child within 30 days of birth or adoption and
- The participant converts from single to family coverage.

You may choose to pay for continuation coverage in monthly installments for each month that you elect coverage. Original payment must be made within the original 60 days in which to elect continuation of coverage and at the beginning of each month thereafter through the last month of coverage.

Please note that in the event of a divorce or legal separation, or a child no longer qualifies as a dependent, **you must notify the Plan office within 30 days of the event, or the date on which coverage would be lost because of the event.** Any continuation coverage (18, 29, or 36 month period) will end for you or your covered dependent(s) when any of the following occurs:

- You fail to pay timely. If this happens, coverage will cease at the end of the period for which payment was made.
- Coverage will end on the day you or your dependents become covered for benefits under another group health benefit program.
- Coverage will end on the day you or your dependents become eligible for Medicare.
- The group health plan ends for all employees.
- The date a former spouse becomes covered under another health plan.
- You are no longer determined to be disabled during your extended period of coverage for up to 29 months (loss of Social Security Disability Pension).
- Your Employer no longer provides coverage for any of his/her employees.

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## General Exclusions And Plan Limitations

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No benefits are payable under this Plan for the charges listed below:

1. Charges for dental care or treatment except as otherwise set forth;
2. Charges for treatments rendered by a Chiropractor except as provided for under Plan A.
3. Confinement in and services and supplies rendered at a hospital operated by the Veteran's Administration (other than as required by law) or other agency of the Federal or State governments; services, supplies or anything else furnished by or for the Federal Government: certain expenses incurred during confinement under other governmental hospitals; expenses resulting from an act of war occurring while covered.
4. Expenses for eye refractions or fitting of glasses, except as provided under Optical Benefits, if any.
5. Cosmetic services or supplies.
6. Elective services such as routine physical examinations, annual check-ups or other services where there is no diagnosis of an injury or illness, except as otherwise provided in the Plan Schedule of Benefits
7. Services, supplies and equipment rendered in connection with accidents, illness or injuries covered by Worker's Compensation legislation.
8. Services, supplies and equipment provided to the donor of an organ transplant, unless both the donor and the recipient are eligible Participants and participants of the same immediate family.
9. Services, supplies and equipment provided in connection with the testing or treatment of infertility, including, for example, in-vitro fertilization or genetic testing or counseling.
10. Services, supplies and equipment provided in connection with a sex change operation.
11. Services, supplies and equipment provided in connection with obesity except morbid obesity.
12. Food, food supplements and services or supplies provided by a dietician or other diet control specialist.
13. Services, supplies and equipment provided in connection with treatment considered experimental or investigative in terms of generally accepted medical standards.
14. Services, supplies and equipment provided in connection with a condition resulting from the illegal act of the individual with the condi-

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tion, or for conditions resulting from a self-inflicted injury or illness (including alcohol and drug abuse) except as otherwise set forth.

15. Services, supplies and equipment provision of which is not necessary for or consistent with the diagnosis and treatment of the accident, illness or injury or which is not recommended and approved by a legally qualified physician.

16. Charges that neither you nor any of your dependents are required to pay.

17. Services, supplies and equipment which are furnished, paid for or otherwise provided for by reason of the past or present service of any person in the armed forces; or which are paid for or otherwise provided for under any law of a government.

18. Nursing care or physiotherapy rendered by you or your spouse, or a child, brother, sister or parent of you or your spouse.

19. Charges that have been paid for by another group insurance plan (see Coordination of Benefits section).

20. Charges to the extent that they are unreasonable, as determined by a schedule held at the Plan office. The monetary rate may vary from benefit program to benefit program because it is determined actuarially within the framework of the negotiated contributions.

21. Charges for a private room in a hospital, which are in excess of semi-private rates.

22. Hospital benefits shall not cover the services of physicians, private nurse or special nurses (except as otherwise set forth).

23. Surgical correction of nearsightedness (radial keratotomy or Lasik surgery)

24. Treatment of corns, calluses, bunions (unless there is capsular or bone surgery), nails of the feet, weak feet, etc.

25. "Congenital Anomalies" shall include both physical disorders and disease resulting from birth. Up to a lifetime maximum of \$50,000 will be paid for all covered eligible expenses in this booklet provided in the treatment of "congenital anomalies."

26. Services in connection with the treatment of Infertility or impotence.

27. Services rendered by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) except as otherwise set forth.

28. Immunizations except as otherwise set forth.

29. Any charges for treatment or services unless specifically stated as covered in the SPD.

# 4.

## Optical Benefits



### **OPTICAL BENEFITS FOR PARTICIPANTS, DEPENDENTS, AND PARTICIPANTS WHO ARE RETIRED ONLY:**

Coverage is provided once each year for an eye examination by an Ophthalmologist (Eye Doctor), or an examination made by an Optometrist. In no event will you receive payment for more than one eye examination each year.

The Plan has made arrangements with three (3) providers to provide optical service to you and your eligible dependents at no cost.

These providers are:

### **General Vision Services, Vision Screening Services and National Optical Services**

Please contact the Plan office for the required forms, the services that will be provided, and the instructions needed for the eye examination and optician's services.

If you do not use one of the above providers, an allowance will be paid for eyeglasses (lenses and frames) once each year provided the glasses are prescribed and the prescription is filled by a dispensing optician in accordance with your Plan Schedule of Benefits.

The allowances are as follows:

Plan "A" Out-of-Network: Examination-\$30 Ophthalmologist, \$25 Optometrist; Glasses-\$30

Plan "4" and "B": Examination-\$25 Ophthalmologist, \$15 Optometrist; Glasses-\$25

Plan "3" and "C": Examination-\$20 Ophthalmologist, \$20 Optometrist; Glasses-\$10.

**No Optical benefits are provided for sunglasses or Laser eye surgery.**

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# 5. Hearing Aid Coverage

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**HEARING AID BENEFIT:**

For eligible Participants who are Retired and Active Participants of Plan "A" only - no benefit payable for a spouse or dependent.

After a \$100 deductible, coverage is provided up to a \$1,500 maximum payment once every five years, with a physician's recommendation.

Covered expenses include the cost & installation of a hearing aid if recommended by a physician or otologist.

**Exclusions:** Hearing Aids not recommended by a physician or otologist, repair and/or replacement batteries.

## 6.

# Dental Care Coverage



## Dental Care Coverage For Eligible Participants, Dependents, And Participants Who Are Retired Only:

Dental Coverage<sup>11</sup> is provided for eligible participants, their eligible dependents, and eligible participants who are retired for covered services performed by a licensed dentist. Those dental expenses incurred by a eligible participant, his/her dependents or an eligible participant who is retired will be paid in full up to the following maximum payments:

- Plan A: \$1,500 per eligible family member per year
- Plan 4: \$1,000 per eligible family member per year
- Plan B: \$1,000 per eligible family member per year
- Plan 3: \$800 per eligible family member per year
- Plan C: \$800 per eligible family member per year

Plan A: **ORTHODONTIC BENEFIT:** There is a lifetime maximum Benefit of \$500.00 for Braces per eligible family member.

The Plan's Dental Plan has a special feature called a "Preferred Provider Organization" (PPO). The PPO feature establishes a network of "preferred providers" where benefits are usually higher. The Plan has made an arrangement with the Dental Guard Preferred Select Network of providers.<sup>12</sup>

**In-Network Coverage:** By choosing a dentist from the PPO Network you will receive a higher level of coverage. In-network dental services will be paid at 100%, subject to the plan maximums set forth above.

**Out-of-Network Coverage:** Dental services provided by an out-of-Network provider will be paid at 60% of billed charges, subject to plan maximums set forth above.

<sup>11</sup>Removal of impacted wisdom teeth (full, partial bony, soft tissue) will be covered under the medical Plan's surgical benefit.

<sup>12</sup>To find a participating provider, check on line at [www.guardianlife.com](http://www.guardianlife.com) and choose the Dental Guard Preferred Select Network. You can also call Alicare at (212) 539-5115.

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Any licensed dentist may be used. However, by accessing a provider in the Dental Guard Preferred Select Network, benefits will be paid at 100% of the Guardian Network rate. By using a provider out of the Network, benefits will be paid at 60% of billed charges.

Benefits will not be paid above the amount actually charged, nor will benefits be paid if the patient does not incur an actual charge by a licensed dentist, nor will reimbursement be made for any amount for which the covered person is not legally liable in the absence of coverage by this Plan. Coverage for dental conditions which existed prior to eligibility for such benefits from this Plan will be provided, but no payment will be made for any dental procedures which were performed prior to the date of eligibility for dental care benefits. The Plan will not be liable for any dental work, which takes place after the termination of eligibility for dental benefits, regardless of circumstances. No dental care benefits will be paid for accidents or illness covered by Workers' Compensation Legislation or for treatments received in hospitals or clinics, etc. operated by Federal or State agencies; nor for any treatment or procedure not set forth in the Schedule of Dental Care Benefits.

## 7.

# Prescription Drug Coverage



## Prescription Drug Benefits For Participants, Dependents and Participants Who Are Retired Only:

Administered through Express Scripts the Prescription Drug Benefits for eligible participants, dependents and participants who are retired are provided if a licensed medical doctor, dentist, or osteopathic physician prescribes drugs which fall into one or more of the following categories:

- Prescription drugs (those which, by law, can be dispensed only with a written prescription).
- Insulin.
- Synagis.
- Disposable needles/Syringes.
- Tretinoin (Resin-A) for individuals through the age of 25 years.
- Compounded medication of which at least one ingredient is a legend drug.
- Oral Contraceptives.
- Injectable Sandostatin.
- Injectable Byetta.
- Sexual enhancement drugs such as Viagra will have an annual limit of \$500 per plan year.
- Injectable Copaxin for the treatment of multiple sclerosis.

### What Is Not Covered:

- Anorectics (any drug used for the purpose of weight loss).
- Growth hormones.
- Minoxidil (Rogaine) for treatment of alopecia.
- Medications sold over the counter.
- Tretincin (Retin-A), (except in cancer care).
- Therapeutic devices and appliances such as orthopedic shoes support garments and other
- Non-medical items.
- Charges for administering or injecting a drug.

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- Prescriptions which an eligible person is entitled to receive without charge from any Workers' Compensation Laws.
  - Drugs labeled, "Caution-Limited by Federal law to investigational use," or experimental drugs.
  - Drugs administered in hospitals, clinics, nursing homes or similar institutions or doctors' offices.
  - Refills in excess of the number specified by physician.
  - Any refill dispensed after one year from the physician's original order.

## **Card Program**

**How Many Will Be Dispensed:** The maximum amount dispensed for each prescription is not to exceed a 30-day supply.

**Where To Buy Your Prescription Drugs:** More than 90% of the pharmacies in the United States belong to the RECAP system, a nationwide electronic link to computers at Express Scripts head-quarters. This sophisticated system enables the pharmacist to submit your insurance claim in a few seconds, with full information and without written claim forms. Ask the pharmacist if you do not see a RECAP sign. When you fill your prescriptions at a RECAP pharmacy, you simply pay your share of the cost of the prescription drug. If you use a pharmacy that does not belong to RECAP, you will be asked to pay the full cost of the prescription drug at the time it is filled. For reimburse, you must fill out a claim form and submit it, along with your sales receipt to Express Scripts. You will receive a check in the mail for the amount you are entitled to, after your share of the cost is deducted from the total.

### **How To Obtain Your Prescription Drugs:**

- Present your doctor's prescription and your Express Scripts prescription drug ID card to a participating pharmacy .
- When you have received your medicine, sign the pharmacy signature log.
- Make sure the pharmacist has full, correct information about you and your family participants, including accurate birth dates.
- Pay your share of the cost.
- Take your prescription drug with you.

### **How Much To Pay - The Copayment**

- You are required to pay a **\$5.00** copayment for generic drugs for each prescription each time you fill that prescription.
- For a brand name drug that does not have a generic you will pay **\$25.00** for each prescription each time you fill that prescription.
- For a brand name drug that has a generic and you or your doctor choose to have the brand name you will have a **\$25.00 copayment in**

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**addition to any charge over and above the cost of the generic equivalent.**

**For example:**

If you choose the brand name drug over the generic drug:

Drug: Zantac Tab 150 mg. (30 day supply)

Brand Cost: \$41.01

Generic Cost: \$30.50

Difference: \$10.51

Your copayment: \$35.51

(You would pay the \$25.00 brand co pay then we would pay \$5.50 (the difference between the brand co payment and the generic cost) then you would pay the remaining balance of the Brand name which is \$10.51 for a total cost to you of \$35.51)

### **Mail Order Program**

**How Many Will Be Dispensed:** The maximum amount dispensed for each prescription is not to exceed a 90-day supply.

**How To Obtain Your Prescription Drugs:**

This part of your prescription drug benefit program is designed especially for those who are taking prescription medication on a long-term basis for treatment of a chronic condition. Any prescription drug that is covered under your card plan and that you will be taking on a long-term basis is eligible for coverage.

To use this program, ask your physician to prescribe needed medications for up to a three month supply. Send a completed form and your original prescription(s) to Express Scripts Mail Service Pharmacy using the envelope provided. Your order will be processed and returned to you via First Class Mail or UPS.

For forms and envelopes, check with your Fund Office — or call Express Scripts at **1-877-415-9980**.

### **How Much To Pay - The Copayment**

- You are not required to pay a copayment for generic drugs filled through the mail order program.
- For a brand name drug that does not have a generic you will pay **\$25.00** for each 90-day prescription each time you fill that prescription.
- For a brand name drug that has a generic and you or your doctor choose to have the brand name you will have a **\$25.00 copayment**

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**in addition to any charge over and above the cost of the generic equivalent.**

**For example:**

If you choose the brand name drug over the generic drug:

Drug: Zantac Tab 150 mg. (30 day supply)

Brand Cost: \$41.01

Generic Cost: \$30.50

Difference: \$10.51

Your copayment: \$35.51

(You would pay the \$25.00 brand co pay then we would pay \$5.50 (the difference between the brand co payment and the generic cost) then you would pay the remaining balance of the Brand name which is \$10.51 for a total cost to you of \$35.51)

**COBRA Coverage:**

If you are covered by COBRA you can only use the mail order program if you have paid your COBRA premium three months in advance.

**A Special Part Of Your Prescription Drug Benefit:**

Occasionally a prescription drug may cause a problem. The problem may be a predictable, perhaps avoidable if your physician and pharmacist were aware of your medical history, current medications and the many different combinations that cause harmful drug reactions. Even top professionals cannot be constantly alert for every patient and every drug. With RECAP, your prescription order is compared to information stored in data banks, taking into account your individual drug history, the possibilities of interaction among various drugs and how long it's been since the last prescription was filled. If the potential for drug related illness exists, an alert message is transmitted electronically to the pharmacist's computer terminal. By reading the message, the pharmacist can inform you, check with your doctor or make a professional judgment whether or not to dispense your prescription.

**Prescription Drug Benefits For Spouses Of Eligible Participants Who Are Retired:**

The Plan will reimburse the maximum amount of \$300 for the previous calendar year for prescriptions within the limitations indicated in the Prescription Drug Benefit provision for the non covered spouse of a participant who is retired (over the age of 65) where applicable.

# 8.

# Death Benefits

## What Is The Amount Of Your Death Benefit?

Death Benefits For Eligible Participants And Participants Who Are Retired: Up to the following amounts will be payable in the event of death from any cause:

	Plan A	Plan 4	Plan B	Plan 3	Plan C
Eligible Active Member up to 69 years	\$50,000	\$10,000	\$10,000	\$10,000	\$10,000
Eligible Active Member 70 years or older	\$10,000	\$5,000	\$5,000	\$5,000	\$5,000
Eligible Retired Member up to 69 years	\$10,000	\$5,000	\$5,000	\$5,000	\$5,000
Eligible Retired Member 70 years or older	\$5,000	\$2,500	\$2,500	\$2,500	\$2,500

## How Is Payment Made

A Death Benefit will be paid to your beneficiary in the event of your death from any cause. A Designation of Beneficiary card must be filled out. These cards are always available at the Plan office. You may change your Beneficiary at any time you desire. If you do not name a beneficiary or if the person you name dies before you, your Death Benefit will be paid as follows:

First: to your wife; or if your wife is not living,

Second: to your children in equal shares; or if there are no children,

Third: to your parents in equal shares; or if neither parent is living,

Fourth: to your estate.

Any attempted assignment by the beneficiary will be considered null and void. In such case, the money will be held by the Trustees for such purposes, as they in their sole discretion deem proper. Where circumstances necessitate, the Trustee will recognize a bill for burial expenses not to exceed \$250. This amount will be deducted from the Death Benefit at the time of final payment.

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# What Happens To Your Death Benefits If You Are Disabled

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## **Totally & Permanently Disabled Participants:**

If you become totally and permanently disabled while you are eligible for Death Benefits from this Plan, your coverage for a Death Benefit will be continued for as long as you remain totally and permanently disabled, provided you fall into one of the following categories:

1. You are under 62 years of age when you become disabled, or...
2. Except for age, you are eligible for a Pension from the Sheet Metal Workers National Pension Plan.

The disability must prevent you from engaging in any kind of employment or business. You will be required to furnish written medical proof of total and permanent disability to the Plan office between the ninth and twelfth month after the beginning of your disability. Subsequent written medical proof of total and permanent disability must be given to the Plan office not less than once each year.

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# 9.

# How Your Rights Are Protected



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As a participant in the Teamsters Local 522 Welfare Plan - Roofers Division, 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 location, 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.

–Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan. If you have creditable coverage from another plan, you should be provided a certificate of creditable coverage free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your

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COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

**Prudent Actions By Plan Fiduciaries:**

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

**Enforce Your Rights:**

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

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

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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, Pension and Welfare Benefits Administration, U. S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## **Your Right To Appeal**

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If your entire claim, or part of your claim is denied, you have the right to appeal. The following appeals procedures apply only to claims for benefits provided under this Plan to Participants.

### **Appeal of Adverse Benefit Determination**

If you disagree with the determination, you may request an appeal of such denial by written request filed with the Plan at least one hundred and eighty ( 180) days after the receipt of the denial notice. Your request for a review must be in writing unless your claim involves urgent care, in which case the request may be made orally.

### **Review Process**

In connection with your right to appeal the initial determination regarding your claim, you:

- will be given the opportunity to submit written comments, documents, records, or any other matter relevant to your claim;
- will be provided, at your request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- will be given a review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, regardless of whether such information was submitted or considered in the initial benefit determination;
- will be provided with the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;
- are entitled to have your claim reviewed by a health care professional retained by the Plan, if the denial was based on a medical judgment; this individual may not have participated in the initial denial; and

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- are entitled to a review that is conducted by a different individual, who is neither the individual who made the adverse benefit determination, nor the subordinate of such individual.

In the case of a claim involving urgent care, you are entitled to an expedited review process pursuant to which all necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and you by telephone, facsimile, or other available expeditious methods.

### **Timeframes for Review and Appeal**

The Plan must issue a review decision on your appeal according to the following timetable:

Urgent Care Claims - not later than seventy-two (72) hours after receiving your request for a review.

Concurrent Care Claims - an appeal of a concurrent care claim will be treated as either an urgent care claim, pre-service care claim, or a post-service care claim, depending on the facts.

Pre-Service Care Claims - not later than thirty (30) days after receiving your request for a review.

Post-Service Care Claims - The Appeals Committee meets four times each year. If your appeal is received more than thirty days prior to the next Appeals Committee Meeting, it will be considered at that meeting. If your appeal is received within thirty days of the next Appeals Committee Meeting, your appeal will be considered at the meeting that follows. You will receive a written decision of the outcome of your appeal within 30 days of the decision. If you lose your appeal, you have the right to file suit in State or Federal Court under section 502(a).

### **Manner and Content of Benefit Determination on Review**

If your appeal under this Plan has been denied, in whole or in part, you will be provided with adequate notice in writing setting forth:

- the specific reasons for the decision;
- references to the specific Plan provisions on which it was based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- a statement describing your right to bring a civil action under section 502(a) of ERISA;

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- a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination, 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, upon request;
  - if the benefit determination is based upon 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 your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

The decision of the Trustees of the Plan (or its designated committee) on review shall be final and binding on all parties.

## **Amendment/Termination Of The Plan**

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The Trustees reserve the right to change or discontinue (1) the types and amounts of benefits under the Plan and (2) the eligibility rules for extended or accumulated eligibility, even if extended eligibility has been accumulated.

Plan benefits and eligibility rules for active, retired, or disabled Participants and their Beneficiaries:

- are not guaranteed;
- may be changed or discontinued by the Board of Trustees;
- are subject to the rules and regulations adopted by the Board of Trustees;
- are subject to the Trust Agreement which establishes and governs the Plan's operations; and
- are subject to the provisions of the group insurance policy purchased by the Trustees. The nature and amount of Plan benefits are always subject to the actual terms of the Plan as it exists at the time the claim occurs.

If the Plan is changed or discontinued, it will not affect you or your beneficiary's rights to any insured benefit to which you have already become entitled.

## **Additional Information**

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The provisions in this booklet are subject to the rules and regulations of the Plan adopted by the Board of Trustees from time to time, and by the Trust Indenture which established and governs the Plan's operation.

The Insurance Plan Office will administer the Plan pursuant to rules laid down by the Board of Trustees. These rules are uniformly applied. Any

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participant may appeal the action of the Insurance Plan Office by requesting a review of his case by the Board of Trustees. Such request must be made within 30 days after the action, by letter addressed to the Board of Trustees at 21-42 44th Drive, Long Island City, NY 11101. The action of the Board of Trustees in any case shall be final, conclusive, and binding on all people.

We are dedicated to providing a high level of benefits at reasonable cost to our Participants. If you have any questions or comments regarding the plan, please feel free to contact the Plan office by calling (718) 937-4514 or by writing to:

SHEET METAL WORKERS INTERNATIONAL

ASSOCIATION LOCAL UNION 137

INSURANCE PLAN

21-42 44th Drive

Long Island City, NY 11101

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## DEFINITIONS/CLARIFICATION

- **Plan** - an arrangement under which employer and employee contributions, if any, are deposited with a trustee who is responsible for the administration and investment of these monies and the income earned on accumulated assets of the plan, and who is normally responsible for the direct payment of benefits to eligible participants under the plan. Benefits are often paid by an insurance company with transfers from the trust plan as required.
- **Self- Insured** - a self-insured plan is one in which no insurance company or service plan collects premiums and assumes risk. In a sense, the union is acting as an insurance company - paying claims with the money ordinarily earmarked for premiums.
- **Coordination of Benefits (COB)** - a group health insurance policy provision designed to eliminate duplicate payments and provide the sequence in which coverage will apply when a person is insured under two contracts.
- **In-Network** - using providers within a group of doctors, hospitals, pharmacies and other health care experts hired by a health plan to take care of its participants.
- **Out of Network** - not using a provider within the group of doctors, hospitals, pharmacies and other health care experts that were hired by a health plan.
- **Mail-Order drug Program** - a method of dispensing medication directly to the patient through the mail by means of a mail-order distribution company.
- **Major Medical Benefits** - coverage that usually pays only a portion of the expense for all covered services (generally involving major illness or injury) and specifies a deductible that the insured must first pay. Maximums may limit total benefits paid.
- **Qualified Medical Child Support Orders** - A judgment, decree, or order that (1) is issued by a court of competent jurisdiction pursuant to a state domestic relations law or community property law; recipient to receive benefits under his or her parent's employer's group health plan; and (3) includes certain information relating to the participant and alternate recipient.
- **Family and Medical Leave Act of 1993 (FMLA)** - entitled employees eligible under the Act to take up to 12 weeks of unpaid, job-protected leave each year for the Employee's own illness, or to care for a seriously ill child, spouse or parent.
- **Uniformed Services Employment and Reemployment Rights Act (USERRA)** - protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service.

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- **"ERISA"** - Employee Retirement Income Security act of 1974.
  - **Pre-Certify** - the process of obtaining certification or authorization from the health plan for hospital admissions (inpatient or outpatient) or for surgery, based on the judgment of medically appropriate care by a qualified peer. Failure to obtain pre-certification often results in a financial penalty to either the provider of the participant.
  - **Allowable Expenses** - means any necessary, reasonable and customary expense incurred while eligible for benefits under this plan, part or all of which would be payable under any of the plans coordinated with this plan.
  - **Dependent** - generally the spouse or child of a covered individual, as defined in a contract.
  - **Legally qualified medical doctor, physician, or surgeon** - as used in this booklet, means a legally qualified Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.), except that, a Doctor of Podiatrist Medicine (D.P.M.) or a Dentist (DDS) will be recognized as a legally qualified physician when performing services in his specialty, which, if performed by an M.D. or D.O. would be covered.
  - **Hospital** - means an institution, which keeps patients regularly overnight, has full diagnostic, surgical, and therapeutic facilities under the supervision of a staff of qualified physicians, and regularly provides 24 hour nursing service by registered graduate nurses. Unless they fully meet the definition, institutions such as clinics, nursing homes, and places for rest, rehabilitation or physiotherapy, convalescence, the aged, drug addicts or alcoholics do not qualify as hospitals.
  - **Participant** - a person who is working for an employer who is making contributions to the Sheet Metal Workers' International Association-Local Union 137 Insurance Plan on their behalf and who has met the requirements to qualify for Plan coverage.
  - **Beneficiary** - a person designated by a participant in the Plan or by the terms of the Plan to receive any benefit that may be payable upon upon the death of the participant.