

**LOCAL #112
SHEET METAL WORKERS
HEALTH CARE PLAN**

SUMMARY PLAN DESCRIPTION

**Effective
January 1, 2021**

**Sheet Metal Workers Local No. 112 Welfare Fund
1200 Clemens Center Parkway
P.O. Box 1146
Elmira, New York 14902-1146**

IMPORTANT NOTICE

THIS PLAN DOES NOT PROVIDE
“GUARANTEED LIFETIME BENEFITS”

The Benefits described in this booklet can be provided only so long as the parties to the Collective Bargaining Agreements continue to require contributions into the Trust Fund sufficient to underwrite the cost of the Benefits. Should contributions cease and the reserves be depleted, there would no longer be an obligation to furnish Benefits. Additionally, changes in the laws may require that changes be made to the benefit structure of this Plan. The Trustees therefore reserve the right to amend the provisions of this Plan at any time based upon the availability of funds, and other relevant considerations.

For further information or claim forms, please call or write the Plan Office:

1200 Clemens Center Parkway
P.O. Box 1146
Elmira, New York 14902-1146
(607-733-9621)

LOCAL #112 SHEET METAL WORKERS
HEALTH CARE PLAN
1200 Clemens Center Parkway
P.O. Box 1146
Elmira, New York 14902-1146

To Eligible Employees:

In its continuing efforts to improve and maintain your health care benefits, your Board of Trustees is pleased to submit this up-to-date benefit plan description providing an overview of the current benefits available to qualified Participants. As you probably know, health care costs and insurance charges have been increasing rapidly over the past few years. There have been a number of changes to the Plan, and this booklet supersedes all prior Plan information. Changes made to the Plan are designed to ensure that the Trust Fund remains solvent in the face of future economic uncertainty in order to continue providing basic benefits to eligible employees and their dependents. In the future, you will also be notified of any changes made by the Trustees or mandated by law.

Both the United States Congress and the New York State Legislature continue to consider sweeping changes to the way that health care and health insurance programs are operated. Therefore, it is very likely that significant changes in the Plan may be mandated by governmental authorities over the next few years.

This booklet, together with the appropriate Certificates of Coverage constitutes your Summary Plan Description and you should pay special attention to those pages which describe your eligibility, termination of eligibility, and procedures to follow to file a claim or process an appeal if you feel that the determination was incorrect.

The term "Certificate of Coverage" refers to the plan documentation provided by BlueCross BlueShield of Central New York, Inc. ("BCBS"), which describes your hospital, surgical, and medical benefits. Certificates of Coverage are sometimes also referred to as Certificates, Evidence of Coverage, Plan Booklets, etc. If you do not have a copy of your Certificate of Coverage, you may obtain one from the Plan Administrator.

You should read this booklet carefully to become aware of your rights, duties and responsibilities so that these benefits will be available to you and your dependents in time of need. We also urge you to share this material with your family because the Plan affects their well-being as much as yours.

Sincerely,
Board of Trustees of the
Sheet Metal Workers Local No. 112 Welfare Fund

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SECTION 1

GENERAL INFORMATION

1. **Overview of Plan.** The Local #112 Sheet Metal Workers Health Care Plan exists and is administered under the “Agreement and Declaration of Trust,” as amended, for the Sheet Metal Workers Local No. 112 Welfare Fund, (the “Fund” or “Trust Fund”). The Trust Fund was originally established on June 25, 1952 between Local #112 Sheet Metal Workers International Association and various employers and employer associations. The Health Care Plan exists for the purpose of providing eligible participants and/or their beneficiaries with medical, surgical, and/or hospital care benefits together with other health-related benefits and coverage for sickness, accident, disability, or death. The overall plan has several separate components, as follows:

Hospital, medical, and surgical benefits;
Vision benefits; and
Medical reimbursement (HRA) benefit.

- (a) **Plan Identification Numbers.** The Plan is identified as follows:

- (1) Plan Name: Local #112 Sheet Metal Workers Health Care Plan
- (2) Plan Sponsor: Board of Trustees, Sheet Metal Workers Local No. 112 Welfare Fund
- (3) Employer Identification Number: 16-6052225
- (4) Plan Number: 501

- (b) **Board of Trustees.** The names and addresses of the Plan’s Trustees are as follows:

Union Trustees:

Donald Kraft, Sr.
1200 Clemens Center Parkway
P.O. Box 1146
Elmira, NY 14902
smw112@verizon.net

Todd Burgess
1200 Clemens Center Parkway
P.O. Box 1146
Elmira, NY 14902
smw112@verizon.net

Ryan Blake
1200 Clemens Center Parkway
P.O. Box 1146
Elmira, NY 14902
smw112@verizon.net

Employer Trustees:

Bill Burge
Charles F. Evans Co., Inc.
PO Box 228
Elmira, NY 14902
bburge@evans-roofing.com

Michael Trengo
AFT Mechanical
120 Ferris St
Elmira, NY 14904
trengom@aftmech.com

Shana Graham
Stamped Fittings
217 Lenox Ave
Elmira Heights, NY 14903
grahams@stampedfittings.com

- (c) **Type and Source of Funding.** The Plan is maintained pursuant to a collective bargaining agreement between contributing Employers and your Union. Employers contribute to the Fund on your behalf.

Medical and hospitalization benefits under the Plan are fully insured. Benefits are provided under group insurance contracts entered into between Blue Cross Blue Shield of Central New York, Inc. (“BCBS”) and the Fund, which will own the group contract providing benefits to all eligible participants. Claims for these benefits are sent to BCBS. BCBS (not your Employer or the Fund) is responsible for paying these claims.

Your medical reimbursement (HRA) benefits are self-insured through the Trust Fund.

- (d) **Source of Plan Benefits.** All medical and hospitalization benefits are furnished under a group insurance contract with Excellus BlueCross Blue Shield (“Insurance Company”).
- (e) **Plan Year.** The Plan Year is the 12 consecutive months from January 1 through the following December 31.
- (f) **Fund Administrator.** In the event that you have any questions concerning the Plan or if you need claim forms, you should call or write:

Fund Administrator
Donald Kraft, Sr.
1200 Clemens Center Parkway
P.O. Box 1146
Elmira, New York 14902-1146
(607) 733 -9621

- (g) **Other Fund Personnel/Advisors.**

Fund Accountants:

The Plan’s financial records are kept on a Plan Year basis (January 1 — December 31). The Plan’s financial records are audited annually by:

Mengel Metzger Barr & Co, LLP
333 East Water Street
Suite 200
Elmira, NY 14901

Fund Attorneys:

Lipsitz Green Scime Cambria LLP
42 Delaware Avenue, Suite 120
Buffalo, New York 14202-3924

2. **Participating Employers.** Upon written request, you may receive from the Plan Administrator, information as to whether a particular employer participates in the sponsorship of the Plan. If the particular employer does participate, you may also request the employer's address.

SECTION 2

ELIGIBILITY

1. **How Plan Coverage Begins and is Maintained.**

(a) **Eligibility through Contributions.** You become eligible for benefits under the Plan if you have been employed in work covered by the collective bargaining agreement of Local No. 112, Sheet Metal Workers International Association ("Covered Employment") and provided that you have worked the required number of hours for which contributions are made to the Plan. Full-time employees of the Union shall also be eligible, and all full-time employees of the Health Care Plan, Pension Plan, Annuity Plan, Industry Education (Apprenticeship) Plan, and/or any other affiliated plan or fund may, with the consent of the Trustees, be eligible; in this connection only, the Employer of such person shall be considered an Employer within the meaning of that term under this Plan and the Declaration of Trust. You must be actively at work or available for work under the collective bargaining agreement on the date that participation is to begin. Employees not actively at work on account of injury or sickness when they would otherwise become eligible will be treated as if they are available for work. Also, you must remain actively at work or be available for work under the collective bargaining agreement in order for coverage to continue in effect under the Plan. Further, you are not considered "available for work" if you have refused a referral of work for which you are reasonably suited.

(1) If you were eligible but your previous participation had terminated for any reason, you must re-qualify as if a new employee, as described in subparagraph (3), below.

(2) Apprentices will become eligible for benefits under the Plan immediately upon attaining 2A status and will remain eligible until the end of the first calendar quarter beginning after the date they attained 2A status. Thereafter, their continuing eligibility will be determined in accordance with the general eligibility rules set forth under the provisions of subparagraph (3), below.

Notwithstanding the foregoing, employees who enter the Industry Education (Apprenticeship) Plan directly as a 2A or higher, must meet the general eligibility requirements under the provisions of subparagraph (3), below, prior to becoming entitled to benefits under the Plan.

(3) If you are a new employee (or a previously terminated Participant), you must work 300 hours or more in Covered Employment within a calendar quarter. You will then be eligible to participate in the Plan and enroll in coverage for you and your family beginning as of the first day of the next calendar quarter. Coverage is effective for the calendar quarter, subject to extension as provided in paragraphs (4) and (5), below. If you were previously covered under the Plan, but do not qualify for coverage to be extended, then coverage expires at the end of the initial coverage period. Thereafter, you and your dependents will be able to obtain coverage at your own expense under the COBRA provisions of the Plan.

(4) Your eligibility for coverage for you and your family will be extended to continue for additional consecutive calendar quarter under the method described in subparagraph (3), above.

(5) Notwithstanding the rules set forth in subparagraphs (1) through (4) above, your eligibility to participate in single or self-only coverage under the Plan will be computed semiannually as of December 31st and June 30th of each year. You will be eligible for single or self-only coverage under the Plan if you have worked 780 hours or more in Covered Employment during the six month period beginning January 1 and ending June 30, or beginning July 1 and ending December 31. Coverage will begin on the following July 1 or January 1, as applicable, and be provided for the immediately succeeding six months.

If you are eligible for single coverage, but not family coverage, you may purchase family coverage by paying the difference in premium to the Fund prior to the beginning of the coverage month.

- (b) **Eligibility for Retirees.** You will be eligible to enroll in subsidized health coverage if you were covered under the Local 112 Health Care Plan at retirement or if you were covered for a minimum of 60 months out of the 84 month period prior to retirement. Time spent working on a full-time basis for the Sheet Metal Workers International Union or an International Union–related entity will be considered coverage under the Health Care Plan. Anyone returning from employment with the Sheet Metal Workers International Union or other International Union – related entity must reapply for coverage hereunder within 30 days of terminating such employment.

The monthly cost of coverage and the amount of your subsidy is explained under Section 5, below.

If you or your Spouse terminates Retiree Coverage at any time prior to attainment of age sixty-five (65), you or Spouse will not ever thereafter be eligible to re-establish Retiree Coverage under the Plan. However, if your Retiree Coverage is terminated because you returned to Covered Employment and thereby qualified for active coverage, you may, upon a subsequent retirement, re-establish Retiree Coverage.

If you are a disabled Retiree who qualifies for Social Security Disability benefits, Retiree Coverage will be available to you only until (a) you become eligible for Medicare or (b) the end of the 29th month from the onset of disability, whichever comes sooner.

If you are a Retiree otherwise entitled to extended or continued coverage as a result of eligibility earned while an active Participant, benefits otherwise available will not be reduced. In such cases, the Plan's rules and benefits will be continued in force with respect to you, but only until such time as your accrued eligibility otherwise terminates.

- (c) **Crediting of Hours.** For purposes of determining a Participant's eligibility, hours of Covered Employment will be credited to the month in which they are paid as reported to the Fund on the employer's remittance reports.
- (d) **Enrollment.** Once you are eligible for benefits, you must complete an application form (available through the Fund office) to enroll yourself and/or your eligible spouse and dependents. New employees must enroll within certain time periods after being hired, as discussed in the BCBS insurance booklet. Otherwise, enrollment generally is limited to the annual open enrollment period that occurs before January 1 of each year.

In certain circumstances, enrollment may occur outside the open enrollment period. The BCBS insurance booklet and paragraph 5 of this Section contain information about special enrollment rights. You must be otherwise eligible for health insurance coverage in order to take advantage of these special enrollment rights.

- (e) **No Bank Hours.** There is no accumulation of "Bank" hours under this Plan. As currently established, this Plan does not allow a Participant to accumulate credit for the purpose of obtaining deferred benefits beyond the next succeeding coverage period.
- (f) **Coverage of Disabled Employees.** In the event a covered employee is totally disabled such that he or she is eligible to receive New York State Disability or Workers' Compensation benefits, the employee and all eligible dependents will continue to be covered under the Plan in accordance with coverage already earned. If, at the end of the current coverage period, the Participant remains unable to return to Covered Employment, then his or her coverage as a Participant will be extended on a one-time basis for an additional three months as a "grace period." If, at the end of this "grace period," the Participant remains unable to return to Covered Employment and does not otherwise qualify in accordance with sub-subparagraph 1(a)(3) or (4), above, then his or her coverage as a Participant will terminate, but he or she will be eligible to purchase continuation coverage at his or her own expense under the COBRA provisions of the Plan described in Paragraph 5, below.

- (g) **Duplicate Coverage.** You are not eligible to participate in the Plan if you are already covered as a Dependent of a Participant. However, your past hours in Covered Employment will be applied to determine your eligibility should you cease to be covered as a Dependent.
- (h) **Special Rules and Reinstatement Provisions Applicable to Persons in Military Service and Returning Military Personnel.** In the event you are eligible for coverage and benefits under this Plan and you are inducted, or enlist voluntarily, or are called into the Armed Forces of the United States of America, coverage and benefits for you, your Spouse, and your dependents will continue under the Plan during the first month beginning after the month in which your military service begins. Such coverage is provided by the Plan at no additional cost. Thereafter, if your military service continues, coverage for you, your Spouse, and your dependents under this Plan terminates at the end of the month indicated in the previous sentence, and you, your Spouse, and/or your dependents are eligible to purchase continuation coverage as described below in accordance with federal law.
- (1) Special Rights if Discharged from Military Service and Return to Covered Employment. Should you be discharged from your military service within 60 months after it began, provide timely notice as set forth below, and provided that you resume work in Covered Employment, eligibility for coverage for you, your Spouse, and your dependents under the Plan will be determined in accordance with the eligibility and coverage status you had attained as of the most recent January 1st or July 1st before your period of military service began,
- (2) If Return to Covered Employment Occurs More than Five Years After Military Service Began. If you do not return to Covered Employment within 60 months from the time your military service began or provide timely notice following your service discharge, you will be treated as a former Participant for the purpose of determining your future eligibility for coverage under the Plan in subsequent semiannual coverage periods.

It is important that you notify your employer of your intent to return to work within specified time periods. The time periods and notification requirements are specified below:

LENGTH OF SERVICE	NOTIFICATION REQUIREMENTS
30 days or less	Notification must occur no later than the beginning of your first full, regularly scheduled workday. Under special circumstances this time period may be extended to as soon as possible after the expiration of eight (8) hours of your first full, regularly scheduled workday.
31 days – 180 days	Notification must occur no later than 14 days after the completion of your length of service. Under special circumstances this time may be extended.
181 days or more	Notification must occur no more than 90 days after the completion of your length of service.

These rights shall pertain to the period of your original enlistment or induction or recall to duty and for such further periods of time as you may be required to serve in the Armed Forces of the United States of America during a given Plan Year. If your eligibility and/or coverage under the Plan terminates under the provisions stated above, or the eligibility and/or coverage of your Spouse or dependents under the Plan terminates under the provisions stated above, or under any other rules or provisions of the Plan, you and/or your Spouse and dependents would be entitled, at your own expense, to purchase continuation coverage as discussed below. Notwithstanding any provision of this Plan to the contrary, a Participant's rights to health insurance coverage hereunder shall be determined in accordance with the Uniformed Services Employment and Reemployment Rights Act (USERRA).

2. **When Your Dependent Coverage Begins.** Once you become covered and eligible for benefits, your dependents are also eligible for coverage. Effective January 1, 2012, your eligible dependents will be determined in accordance with the Certificate of Coverage provided to you for your BlueCross health and hospitalization insurance coverage.

IMPORTANT NOTICE

Reporting Family Status

To make sure all of your dependents are covered, it is important that you notify the Plan Office within 30 days of any change in your family status. *Events* which should be reported include marriage, separation, divorce, birth or adoption of a child,

ineligibility of your enrolled children, or the death of a dependent.

3. **When Coverage Ends.** Unless extended as provided above or terminated sooner (for example, through an employee's death, non-availability for Covered Employment, or refusal of suitable employment or any other rule or provision of the Plan), all coverages under the Plan expire at the end of the current coverage period, regardless of whether the Participant's coverage is an interim three-month coverage period, a disability "grace period," or a regular semiannual coverage period (January 1 - June 30 or July 1 - December 31). Eligibility for further coverage in succeeding coverage periods is based upon satisfaction of the established eligibility requirements for each succeeding period as well as the payment and receipt of employer contributions based upon all hours worked in Covered Employment. Participants who do not meet any of the eligibility requirements will only be able to obtain coverage under the Plan at their own expense through the purchase of COBRA continuation coverage as described in paragraph 6, below.

4. **Other Circumstances that Could Result in a Cessation of Benefits Under the Plan.** In compliance with applicable federal law, no benefit under this Plan is vested or non-forfeitable. An individual's loss of eligibility, misstatement, omission, or concealment on a benefit claim, changes in the Plan or applicable law could all result in a cessation of benefits under the Plan. Under certain other circumstances, you may also lose entitlement to all or part of the benefits stated in this booklet. Some of these other situations that could result in such a loss are:

- (a) if the terms of a Qualified Medical Child Support Order (QMCSO) take away part, or all, of your benefits;
- (b) if any detail regarding your participation under the Plan, or your Spouse's or dependent's participation under the Plan, has been misstated, omitted, concealed, or if a clerical error occurs, which causes a higher benefit to be paid you, your Spouse, or your dependent than that to which you, your Spouse, or dependent would otherwise be entitled under the terms of the Plan, an adjustment in such benefit payment must be made, based upon the facts, and any overpayment must be repaid to the Trust Fund;
- (c) if you are judged guilty of causing a loss in Plan assets, you may, under certain circumstances, forfeit all or part of your benefits; and
- (d) if the Plan terminates and there are not enough assets to provide you with benefits as described in this booklet, there may be a reduction in the benefits available to you.

5. **Special Enrollment Rights.**

- (a) **Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program).** If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents

in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

- (b) **Loss of Coverage for Medicaid or a State Children's Health Insurance Program.** If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.
- (c) **New Dependent by Marriage, Birth, Adoption, or Placement for Adoption.** If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- (d) **Eligibility for Medicaid or a State Children's Health Insurance Program.** If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

6. **COBRA.** COBRA continuation coverage allows you and your dependents an opportunity to temporarily extend your health insurance coverage under the Plan at group rates in certain instances where coverage would otherwise end. New York State continuation coverage, known as "mini-COBRA," provides rights similar to federal COBRA to a member of a group covered by a health insurance contract issued in New York.

- (a) **Eligibility.** You or your dependents that are eligible to purchase continuation coverage are "qualified beneficiaries." If a child is born to or adopted by or placed for adoption with an employee during a period of COBRA continuation coverage, the newborn or newly adopted child's maximum continuation period shall be measured from the date of the initial qualifying event and not from the subsequent date of birth or adoption or placement for adoption.

The events which may entitle you or your dependents (as qualified beneficiaries) to continuation coverage are “qualifying events.” The qualifying events, the qualifying beneficiaries, and the maximum continuation period are described in the following chart:

Qualifying Event	Qualified Beneficiary	Continuation Period (Months)
Reduced hours* or termination of employment **	Employee and Dependents	18 or 36 for insured plans***
Employee’s death	Dependents	36
Employee’s entitlement to Medicare	Dependent not entitled to Medicare	36
Dependent child becomes ineligible for coverage	Ineligible Dependent	36
Employee’s divorce/legal separation	Dependents	36

* A reduction in hours due to family or medical leave, as defined by the Family and Medical Leave Act of 1993 (“FMLA”), shall not cause an employee’s participation to terminate, to the extent required by FMLA. Thus, a reduction in hours pursuant to an FMLA leave shall not constitute a qualifying event. However, if the employee does not return to work at the end of the FMLA leave, a qualifying event shall occur as of the last day of the FMLA leave.

** Continuation coverage is not available if employment is terminated for gross misconduct.

- (b) **Notice Requirements.** A qualified beneficiary must inform the Plan Administrator of a divorce or legal separation, or of a child losing dependent status under the plan, within sixty (60) days after the later of: the date of the qualifying event or the date the qualified beneficiary loses health coverage on account of that qualifying event. If timely notice is received, the Plan Administrator has the responsibility to notify BCBS of the divorce, legal separation or loss of dependent status. Your employer also has the responsibility to notify BCBS of your death, termination of employment, reduction in hours, or Medicare entitlement.

BCBS will notify all eligible qualified beneficiaries of their right to elect continuation coverage. If a qualified beneficiary chooses to purchase continuation coverage, the qualified beneficiary must notify your employer in writing within sixty (60) days after the later of: the date the qualified beneficiary loses health coverage on account of the qualifying event or the date on which the qualified beneficiary is sent notice of his or her eligibility for continuation coverage. If the qualified beneficiary does not choose continuation coverage during the sixty (60) day period, his or her participation will end as otherwise provided in the Plan Booklet.

- (c) **Coverage.** If a qualifying event occurs, you and your dependents who are qualified beneficiaries must be offered the opportunity to elect to receive the group health coverage that is provided to similarly-situated nonqualified beneficiaries. Generally, this means that if you or your dependents purchase

continuation coverage, it will be the same as the health coverage provided to you immediately before the qualifying event. Each qualified beneficiary has the right to make an independent election to receive continuation coverage.

Qualified beneficiaries do not have to show that they are insurable in order to purchase continuation coverage. If coverage is subsequently modified for similarly-situated participants, the same modifications will apply to you and your dependents. Qualified beneficiaries who purchase continuation coverage will have the opportunity to elect different types of coverage during an annual open enrollment period in accordance with the opportunity to provide similarly-situated active employees.

- (d) **Cost.** Generally, the qualified beneficiary must pay the total cost of continuation coverage. This cost may be up to 102% of the cost of identical coverage for similarly situated participants.

The initial premium must be paid within forty-five (45) days after the qualified beneficiary elects continuation coverage. Subsequent premium must be paid monthly, as of the first day of the month, with a thirty (30) day grace period for timely payment. However, no subsequent premium will be due within forty-five (45) days after the qualified beneficiary elects continuation coverage. Payment is considered made on the date on which it is sent to the plan.

- (e) **Termination.** Generally, continuation coverage terminates at the end of the 36-month continuation period. However, continuation coverage for a qualified beneficiary may end before the end of the continuation period for any of the following reasons:

- **Coverage Terminated**
Employer no longer offers a group health plan to any of its employees;
- **Unpaid Premium**
The premium for continuation coverage is not timely paid;
- **Other Coverage**
The date on which a qualified beneficiary first becomes, after the date of the election of continuation coverage, covered under another group health plan. However, this provision does not apply during any time period the other group health plan contains any limitation or exclusion with regard to any pre-existing conditions, other than a limitation or exclusion which does not apply to the qualified beneficiary or is satisfied by the qualified beneficiary due to the Health Insurance Portability and Accountability Act;
- **Medicare**
The date on which a qualified beneficiary first becomes, after the date of the election of continuation coverage, entitled to Medicare (Part A or Part B); or

- **Cause**

The date on which a qualified beneficiary's coverage is terminated for cause on the same basis that the plan terminates for cause the coverage of similarly-situated nonqualified beneficiaries (e.g., for fraud or misrepresentation in a claim for benefits).

- (f) **New York's Age 29 Law.** Your children may have the right to elect coverage under New York's Age 29 Law in lieu of COBRA or state continuation coverage. BCBS will notify you of this right. The Plan will permit your child to continue pharmacy coverage for as long as your child is entitled to BCBS coverage under New York law.

7. **Family and Medical Leave Act (FMLA) And New York Paid Family Leave Law.** If you are eligible for, and are granted leave by your Employer under the Family and Medical Leave Act of 1993, (the "FMLA") and/or the New York Paid Family Leave Law (the "PFL") you will be entitled to health and hospitalization insurance coverage under the plan throughout the duration of your leave, but your Employer must continue to contribute to the Plan during that period the monthly premium established by the Plan in order for you to continue your coverage. You will receive the type of coverage (*i.e.*, family or single) you were receiving prior to the leave, subject to any change you may have in family status.

If you fail to return to work after a period of unpaid FMLA leave entitlement has been exhausted or expires, your employer may bill you for the costs to maintain health and hospitalization insurance coverage for the term of the unpaid leave, unless the reason you did not return is due to:

- a continuation, recurrence, or onset of a serious health condition, which entitles you to leave under the FMLA; or
- other circumstances beyond your control as defined in the FMLA and the regulations thereunder.

Questions regarding your entitlement to FMLA or PFL leave should be referred to your Employer.

Questions about the continuation of medical and dental coverage during leave, if available, should be referred to the Fund Office.

If coverage is terminated for failure to make payments while you are on an approved family or medical leave of absence, coverage for you and your eligible dependents will be automatically reinstated on the date you return to employment if you and your dependents are otherwise eligible under the plan. However, all accumulated annual and lifetime maximums will apply.

If you do not return to work at the end of an FMLA or PFL leave, you may be entitled to elect COBRA Continuation Coverage, even if you were not covered under the Plan during the leave. Coverage continued under this provision is in addition to coverage described below under the section entitled "Continuation Coverage (COBRA)."

8. **Coordination of Benefits.** The coordination of benefits rules sets out rules for the order of payment of medical benefits when two or more plans—including Medicare—are paying. If you are covered by this Plan and another plan, or your spouse is covered by this Plan and by another plan, or your dependent children are covered by two or more plans, the plans will coordinate benefits when a claim is received. The rules for determining which plan pays first are set forth in the BCBS insurance booklet. The Plan Sponsor will also use these rules for determining which plan will pay vision benefits.

9. **Plan's Right to Recovery/Reimbursement.**

- (a) If, after benefits have been paid under this Plan on account of services, supplies, or treatment received by you or your dependent(s), it is established that you or your dependent(s):
- (1) Did not pay for the services, supplies, or treatment;
 - (2) Received reimbursement for services, supplies, or treatment (for example, no-fault medical payments); or
 - (3) Received a personal injury award as the result of the any legal action or settlement;
 - (4) Then you must reimburse as follows:
 - (i) If you did not pay for the services, supplies, or treatment, you must repay the full amount paid by the Plan or insurance company for such services, supplies, or treatment;
 - (ii) If you were reimbursed for the services, supplies, or treatment, you must pay the amount for the reimbursement you received, up to the amount paid by the Plan or insurance company, over to the Fund;
 - (iii) If you received a personal injury award or settlement, you must pay the full amount of the award or settlement proceeds received, regardless of how characterized and regardless of any fees or costs charged to you by attorneys or other agents employed by you in obtaining the award or settlement, or the full amount of all expenses paid by the Plan or insurance company for the injuries in question, whichever is less, over to the Fund.
- (b) Additionally, the Plan shall be subrogated to any claim on behalf of you, your Spouse, or your dependent in order for the Fund to recover benefits paid from a party whose negligent or wrongful actions or omissions cause or are responsible for any injury or illness to you, your Spouse, or your dependent. Unless applicable law does not permit such recovery, the Fund is entitled to recover its payments up to the amount of benefits the Plan has paid for related expenses, and to facilitate this recovery, the Fund may intervene and participate in any claims or litigation process you initiate or undertake.

SECTION 3

BENEFITS

1. **Health, Hospitalization, Medical and Surgical Coverage.** Hospital and medical benefits under the Plan are fully insured. Benefits are provided under a group insurance contract entered into between Blue Cross Blue Shield of Central New York (“BCBS”) and the Fund, which will own the group contract providing benefits to all eligible participants. The insurance carrier will provide you with a booklet or certificate describing the insurance benefits provided by that carrier.

The booklet or certificate will contain the following information:

- The eligibility conditions for any dependent coverage
- A summary of benefits
- A description of any deductibles, coinsurance or co-payment amounts
- A description of any annual or lifetime caps or other limits on benefits
- Whether and under what circumstances preventive services are covered
- Whether and under what circumstances prescription drugs are covered
- Whether and under what circumstances coverage is provided for medical tests, devices and procedures
- Provisions governing the use of network providers (if any). If there is a network, the booklet or certificate will contain a general description of the provider network and you will be entitled to obtain a list of providers in the network from the Insurer
- Whether and under what circumstances coverage is provided for out-of-network services
- Any conditions or limits on the selection of primary care physicians or providers of specific specialty medical care
- Any conditions or limits applicable to obtaining emergency medical care
- Any provisions requiring pre-authorization or utilization as a condition to obtaining a benefit service
- A summary of claims procedures

If you need specific information regarding the extent of your medical and hospitalization coverage under this Plan, the benefits offered through your insurance, or how to make a claim for benefits, you should contact BCBS at the following address and telephone number:

2. **Vision Benefits.** The Trustees provide vision benefits through the Fund on a self-insured basis. This benefit is administered by Davis Vision. Generally, you will access your benefits through participating optical stores and doctors by identifying yourself as a Participant in the Plan. You can view the vision benefit guide on the Davis Vision website at:

www.davisvision.com

Additional information regarding your vision benefit is available from the Plan Administrator.

4. **Health Reimbursement Arrangement.** If you are eligible to receive health and hospitalization insurance benefits under the Plan, you will be eligible to participate in the Local 112 Sheet Metal Workers Health Reimbursement Arrangement (“HRA”) and receive a benefit in an amount determined by the Trustees. This benefit will be credited to a HRA Account that the Trustees will establish for you.

The Trustees will determine a maximum annual amount that may be credited during the Plan Year to the HRA Account of each Participant in the HRA benefit. This amount is known as a Benefit Credit and will be credited as contributions to the Plan are received from your employer. Benefit Credits may be revised by the Trustees from time to time subject to the conditions and limitations of the Plan.

Effective May 1, 2016, the benefit credit will be \$1.00 for each hour you work in Covered Employment that is received from your Employer. These amounts will be credited to your HRA only after you have met the eligibility requirements for insurance benefits under the Plan and are enrolled in coverage. Only contributions received for the two calendar quarters immediately preceding your enrollment date will be credited to your HRA.

In addition, if you are eligible for coverage under the Local #112 Plan, and waive that coverage, you will receive an additional HRA benefit credit of \$3.00 for each hour in Covered Employment for which the Plan receives contributions from your Employer, up to \$6,000 in any Plan Year. See **How and When to Waive Coverage**, below.

The HRA is a benefit program that allows you to obtain reimbursement of qualified medical expenses not otherwise reimbursed or reimbursable in full by any other accident or health plan with tax-free funds provided by employers from the HRA Account. **Participation in this HRA Plan does require you to be enrolled and participating in a group health plan, either the Local 112 Plan or through your spouse’s or parent’s employer concurrent with your enrollment and participation in this program.** If you elect to be enrolled in this HRA program for your spouse or covered dependents, your spouse and your covered dependents must be enrolled in a group health plan at the same time. Covered dependents can be covered under this plan on a pre-tax basis until the end of the calendar year in which the child reaches age 26.

You may not participate in this program if you receive health insurance coverage as a spouse or dependent under the Local 112 Sheet Metal Workers Health Plan. Further, sole proprietors, partners in a partnership, members of Limited Liability Companies, and more than two percent

owners of S-Corporations and certain relatives are not eligible to participate in this Plan on a pre-tax basis.

a. **How And When To Waive Coverage.** You may waive coverage during an annual enrollment. If you are a newly hired employee, you must make your decision during any period immediately preceding your becoming eligible.

In order to waive coverage under the Local #112 Plan you must be enrolled in your spouse's or parent's plan, and that plan must provide "Minimum Value." A health plan provides Minimum Value if the health plan's share of the total allowed cost of benefits is at least 60 percent (i.e., has an actuarial value of at least 60 percent). You will be eligible to waive coverage under the Local #112 Plan only if you present your enrollment card in your spouse's or parent's group health plan and provide a copy of that plan's Summary of Benefits and Coverage (SBC) indicating that it meets the Minimum Value standard.

If you are already a participant in the HRA and you fail to complete an election form for the upcoming coverage Plan Year, then you will maintain enrollment in the HRA based on your current group health plan coverage, until changed by an approved Change of Status election.

b. **Change of Status.** Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, you can change your election if you if have a special enrollment event as set forth in paragraph 5 of Section 2 of the Summary Plan Description. In such a case, you may elect coverage for the balance of the calendar quarter so long as you are working or available for work in Covered Employment, but continued coverage requires that you meet the Plan's quarterly eligibility requirements.

You may also change your election on an open enrollment date (January 1) so long as you otherwise meet the eligibility requirements for health insurance coverage under the Plan.

c. **Schedule Of Benefits.** The Trustees will maintain an "HRA Account" in your name to keep a record of the amounts available to you for the reimbursement of Qualified Medical Expenses. Your HRA Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Fund), and it does not bear interest or accrue earnings of any kind. Benefits must first be reimbursed from any health insurance plan, except a Health FSA account, before any benefits are payable from this HRA.

During the Plan Year, you may be reimbursed for Qualified Medical Expenses up to the maximum Benefit Credit amount available to you, less any prior reimbursements. No payment may be made for any medical expense incurred by you before your effective date of coverage or incurred or paid on or after the date of actual termination of participation subject to COBRA Continuation Coverage. The Trustees reserve the right to discontinue or modify coverage at any time.

Qualified Medical Expenses eligible to be reimbursed from the HRA Account are those that are not eligible for reimbursement under any other plan or any other source, including another health reimbursement account or flexible spending account, and are medically necessary expenses that are incurred by you, your spouse, and your Dependents during the Plan Year for medical care as

defined in Section 213(d) of the Internal Revenue Code. You may include all medical, dental, and vision expenses for the diagnosis, cure, treatment or prevention of disease, and for treatments affecting any part or function of the body that are not covered or not reimbursed by insurance or any other source. Expenses may also be to alleviate or prevent a physical defect or illness. Expenses incurred solely for cosmetic reasons or expenses that are merely beneficial to a person's general health are not eligible for reimbursement. Medical expenses qualify for reimbursement based on when they are incurred and are considered incurred at the time the drugs, medical equipment, or medical care service is provided, not at the time you pay for them.

For purposes of this HRA benefit only, Dependents include your spouse and any child of yours who will be under age 27 as of the end of the calendar year, provided your child is covered under your policy or your spouse's policy. For this purpose, a "child" is an individual who is your son, daughter, stepson, or stepdaughter, and includes both a legally adopted individual and an individual lawfully placed with you for legal adoption.

Expenses incurred for medicines or drugs on or after January 1, 2020, may be reimbursed on a tax-free basis from your HRA Account even if the medicine or drug is an over-the-counter (OTC) medicine or drug purchased without a prescription. You may also be reimbursed for menstrual care products and other OTC medical care items other than medicines and drugs (e.g. equipment, supplies, and medical devices, including items such as crutches, bandages, Blood sugar test kits, and eyeglasses).

d. **Carryover of HRA Account.** If any balance remains in your HRA Account after all reimbursements have been made for a Plan Year, that balance will be carried over to reimburse you for Qualified Medical Expenses incurred during a subsequent Plan Year. The balance in your HRA Account will be forfeited and added to the Fund's reserves at the end of a period of twenty-four (24) consecutive months in which there is no contribution to, or distribution from your HRA Account. Further, any balance remaining in your HRA Account upon your death (if you are not survived by a spouse or eligible Dependents), or upon the death of the survivor of your spouse or eligible Dependents, will be forfeited and added to the Fund's reserves.

You will have the option each year at open enrollment, and upon your retirement or termination from Covered Employment, to permanently opt out of HRA Account coverage. If you do so, your entire HRA Account will be forfeited. This allows you to apply for a premium tax credit for health insurance coverage through the new health insurance exchanges, if you would otherwise qualify. This is only optional; if you wish, you may continue to use your HRA after your retirement, and your spouse and dependents may use it upon your death.

e. **Claims.** The HRA Plan will reimburse you for Qualified Medical Expenses to the extent that you have a positive balance in your HRA Account. The following procedure should be followed:

- You may use the debit card issued under this Plan or you must submit a claim to the Claims Administrator and provide any additional information requested by the Claims Administrator;
- A request for payment must relate to the Qualified Medical Expenses incurred during the time you were covered under this Plan; and

- Claims must be submitted in writing (unless a debit card is used).

Claims may be submitted directly to the Claims Administrator:

ProFlex Administrators, LLC
8321 Main Street
Williamsville, NY 14221
Phone - 716-633-2073
Fax - 716-929-2013
www.proflextpa.com

- Complete a Claim Form, found at www.proflextpa.com, and attach additional information as required.
- You will be reimbursed directly for Qualified Medical Expenses.

The claim or in the case of a debit card transaction where the Plan has requested additional information the documentation must set forth:

- The person or persons on whose behalf the Qualified Medical Expenses were incurred;
- The nature and date of the Qualified Medical Expenses so incurred;
- The amount of the requested reimbursement; and
- A statement that such Qualified Medical Expenses have not been otherwise reimbursed and is not reimbursable through any other source.

Each written claim must be accompanied by bills, invoices, or other statements from an independent third party showing that the Qualified Medical Expenses have been incurred and showing the amounts of such Qualified Medical Expenses, along with any additional documentation that the Administrator may request.

If you use a debit card, you must certify that the debit card will only be used to pay for Qualified Medical Expenses for you, your Spouse and eligible Dependent(s). You will be required to make this certification each Plan Year. Your failure to do so will prohibit you from enrolling in the debit card program.

In the event that a claim was reimbursed in error, you will be required to reimburse the Plan for the improper payment. If you fail to reimburse the Plan, the Trustees may offset any future claims until the improper payment is fully recouped, and restrict or deny your access to the debit card to recoup the improper payment. If the improper payment is not recouped, the Trustees may take any action it would normally take for any other business indebtedness to recoup the improper payment.

f. **Claims Procedure.** If a claim for reimbursement under this HRA is wholly or partially denied, claims shall be administered in accordance with the claims procedure set forth in Section 4, below.

g. **Future of the HRA Benefit.** The HRA is based on the Trustees' understanding of the current provisions of the Internal Revenue Code, and relevant Department of the Treasury

rulings. The Trustees reserve the right to amend or discontinue the HRA benefit if regulations or changes in the tax law make it advisable to do so.

SECTION 4

CLAIMS FILING AND APPEAL PROCEDURES

1. **Claims Procedure – Hospital and Medical Claims.** BCBS is responsible for evaluating all insured hospital and medical benefit claims under the Plan, and will decide your claim in accordance with its own claims procedures. BCBS has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If BCBS denies your claim, in whole or in part, you will receive a written notification setting forth the reasons for the denial. See the Plan Booklet issued by BCBS for more information about how to file a claim and for details regarding their claims procedures.

If your claim is denied, you may appeal to BCBS for a review of the denied claim. They will decide your appeal in accordance with their own appeal procedures. See the Plan Booklet issued by BCBS for more information about how to appeal a denied claim and for details regarding their claims procedures.

2. **Claims Procedure – Vision Claims.** Coverage decisions are based on members' benefits and the information submitted with their claims. A Davis Vision Member Services Representative (MSR) can provide more information about how your coverage was applied and answer any questions you may have about your benefits. To reach a representative, please call (800) 999-5431.

If all or part of a claim was not covered, you have a right to see, upon request and at no charge, any rule, guideline, protocol or criterion that Davis Vision, Inc. relied upon in making the coverage decision. If a coverage decision was based on medical necessity or the experimental nature of the care, you are entitled to receive upon request and at no charge the explanation of the scientific or clinical basis for the decision as it relates to the patient's medical condition.

If after speaking with a MSR you feel that our coverage decision was not correct, the patient or an authorized representative may appeal the decision by following the steps below.

To appeal or grieve a coverage decision regarding vision benefits, please send to the address below a written explanation of why you feel the coverage was incorrect. Unless your plan specifies otherwise, this information may also be provided to a MSR over the phone. Please include with the explanation:

- The patient's name, relationship to member, address and telephone number;
- Your Davis Vision, Inc. identification number;

- If applicable, the name of the health care professional or facility that provided the service, including the date and description of the service(s) provided and the charges(s).

Send written appeals to:

Davis Vision, Inc.
Attention: Quality Assurance / Patient Advocate Department
P.O. Box 791
Latham, NY 12110

Members must file an appeal within 180 days of the date of this Explanation of Benefits notification of coverage decision. Davis Vision, Inc. will respond in writing to appeals within 60 calendar days.

3. **Claims Relating to Employee Eligibility and HRA Claims.**

- (a) **Claims Process.** Claims for benefits that are insured (*e.g.*, health and hospitalization insurance) will be reviewed in accordance with procedures contained in the insurance contracts. These procedures are set forth in the booklets provided by the insurance company. If you need an additional copy, you may obtain one free of charge from the Fund office.

If your claim is denied based on your eligibility for coverage, or if your claim relates to a request for reimbursement from your HRA, then this paragraph applies.

Health claims are divided into four categories. Different time lines and processing apply to each category. Listed below is a brief description of each category and the timeline and processing rules that apply to each.

- (b) **Urgent Care Claim.** The term “Urgent Care Claim” means a claim for medical treatment or care, which, if denied could seriously jeopardize your health or life or your ability to regain maximum function, or, in the opinion of a physician who has knowledge of your medical condition would subject you to severe pain that cannot be adequately managed without the care or treatment that is subject to the claim.

The Fund Administrator will notify you of the determination (whether adverse or not) within 72 hours after receipt of your claim, provided there is sufficient information to make a determination. In such case the Fund Administrator will notify you of your failure to provide sufficient information within 24 hours after they receive your claim. You will have 48 hours from receipt of the notice to provide the information needed. The Fund Administrator will notify you of the determination no later than 48 hours after receipt of the required information or, if you fail to provide the required information, the end of the 48-hour period you were given to provide such information. The Fund Administrator may orally notify you of the determination. If notification is provided orally, you will also

receive written notification within 3 days after such oral notification.

- (c) **Pre-Service Claims.** The term “Pre-Service Claim” means any claim for benefits that is made prior to receiving medical care or treatment.

Examples of Pre-Service Claims are:

- A request for pre-approval under a utilization program;
- A request for prior authorization of a medical service, care or treatment; or
- A request for prior authorization to receive a higher percentage of the benefit (e.g. 80% of the cost of the pre-authorized service versus 50%).

The Fund Administrator will notify you of the determination (whether adverse or not) within 15 days after receipt of your claim. Under special circumstances this time frame may be extended one time for an additional 15-day period. In such case the Fund Administrator will notify you of the extension prior to the end of the initial 15-day period. Such notification will include the special circumstances requiring the extension and the date by which the Plan expects to render a determination. If extension of time is needed because of your failure to provide sufficient information to make a determination, the Fund Administrator will notify you of your failure no later than 5 days after receipt of your claim. Such notification may be oral, unless you or your authorized representative request it in writing, and will specify all information needed to make a determination. You will have 45 days from the date you receive notification to provide the required information.

- (d) **Post-Service Claims.** The term “Post-Service Claim” means any thing other than a Pre-Service Claim and includes whether the claimant is eligible for the particular medical service or treatment.

It is important to note that a post-service claim includes a claim that was initially a pre-service claim. (i.e., a subsequent denial or restriction of a pre-certified claim could be affected by this rule.)

If your Post-Service Claim is denied in whole or in part, the Fund Administrator will notify you in writing within 30 days after receipt of your claim. Under special circumstances this time may be extended for an additional 15 day period. The Fund Administrator will notify you of the extension in writing prior to the expiration of the initial 30 day period. Such notification will include the special circumstances requiring the extension and the date by which the Plan expects to render a determination. If extension of time is needed because of your failure to provide sufficient information to make a determination, the notification will specify all required information. You will have 45 days from your receipt of the notification to provide such information.

- (e) **Concurrent Care Decisions.** In the event that the Plan has approved a benefit for ongoing care or treatment (Concurrent Care) and later notifies you that your benefits are going to be terminated or reduced (for reasons other than by Plan amendment or termination) the Plan will notify you of such adverse benefit determination prior to the reduction or termination of your benefit.

If you would like to extend the course of treatment you are receiving beyond the approved period of time or number of treatments, for claims involving urgent care, you may submit a claim to the Fund Administrator at least 24 hours prior to the expiration of the approved period of time or number of treatments. The Fund Administrator will make a determination as soon as possible but no later than 24 hours after receipt of your claim.

- (f) **Notification Requirements.** The Fund Administrator must notify you of the determination of your claim within the specified time limits mentioned above. With regard to all initial benefit claims such notification can be in writing or electronically transmitted and contain the following information:

- The specific reason or reasons for the adverse benefit determination;
- Reference to the specific Plan provisions on which the determination is based;
- A description of any material or information necessary for you to perfect the claim and an explanation of why such information is necessary;
- A description of the plan's 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 the Act following an adverse benefit determination on review.
- If an internal rule, guideline, protocol, or other similar criteria was used in making the adverse benefit determination; specify what was used and that it will be provided to you free of charge upon request; and
- If an adverse benefit determination is based on a medical necessity or experimental treatment, the Plan must provide 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;
- If an adverse benefit determination concerning an urgent care claim, the Plan must include the expedited review process in the notice.

4. **Claim Appeal Procedures.** The following summarizes the procedures that will be utilized by the Plan if your claim for a particular benefit is denied, and you subsequently appeal that decision. As with the general claims procedures above, the timing and requirements vary depending on how the particular claim is categorized.

- (a) **Urgent Care.** Within 180 days after your claim is denied, you may request a review of your claim through oral or written communication to the Fund Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your authorized representative may review pertinent documents free of charge and submit pertinent issues and comments orally, in writing, through facsimile or other electronic means. The Trustees will review your appeal and will notify you of their determination within 72 hours after receipt of your appeal.

- (b) **Pre-Service Claims.** Within 180 days after your claim is denied, you may submit your claim for reconsideration to the Fund Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your authorized representative may review pertinent documents free of charge and submit pertinent issues and comments in writing. The Trustees will review the appeal and provide you with their determination no later than 30 days after receipt of your appeal.

- (c) **Post-Service Claims.** Within 180 days after denial, you or your authorized representative may submit a written request for reconsideration of your claim to the Fund Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents free of charge and submit pertinent issues and comments in writing. The Trustees will review the claim and provide, as soon as possible but no later than the date of the first Board meeting following the date the Plan receives your request for review, a determination. If your request for review is filed within thirty (30) days prior to the date of such meeting a determination will be made no later than the date of the second Board meeting following the date the Trustees receive your request for review. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, the Fund Administrator will notify you in writing describing the special circumstances and the date by which a determination will be rendered. The determination will be made no later than the date of the third Board meeting following the date the Trustees receive your request for review. The Fund Administrator will notify you in writing of the Trustees determination as soon as possible but no later than five (5) days after the determination is made. In this response, the Trustees will explain the specific reason for the determination, with specific reference to the provisions of the Plan on which the decision is based.

- (d) **Concurrent Care Decisions.** In the event that your appeal is with regards to a concurrent care decision, you will follow the procedures listed above as they apply. For instance if you are appealing a claim concerning urgent care you would follow the appeals procedures for urgent care claims.

In rendering a determination of your appeal the Trustees will consult with a health care professional that has appropriate training and experience in the field of medicine pertinent to your claim. Such health care professional will not have been involved in the determination of your initial claim for benefits. The Trustees will make their determination based in whole or in part on such health care professionals' medical judgment.

(e) **Notification Requirements.** The Fund Administrator will notify you of the determination of your claim within the specified time limits mentioned above. With regards to all claims on appeal such notification can be in writing or electronically transmitted and contain the following information:

- The specific reason or reasons for the adverse benefit determination;
- Reference to specific Plan provisions on which the benefit determination is based;
- Statement that you are entitled to receive, upon request and free of charge, reasonable access and copies of all documents, records, and other information relevant to your claim for benefits;
- Statement describing any voluntary appeals procedures offered by the plan, your right to obtain such information and your right to bring civil action under §502(a) of the Act;
- If an internal rule, guideline, protocol, or other similar criteria was used in making the adverse benefit determination; specify what was used and that it will be provided to you free of charge upon request;
- If adverse benefit determination is based on a medical necessity or experimental treatment, the Plan must provide 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 following statement: “You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”

SECTION 5

RETIREE BENEFITS

1. **Retiree Coverage.**

IMPORTANT

Health Care Plan coverage for retirees has not been negotiated as a part of the collective bargaining process nor is it part of the agreements between the Union and contributing employers. This coverage will continue to be available only so long as the Trustees in their sole judgment believe that it is feasible to continue to offer such coverage. The Trustees reserve the right to modify, suspend, or permanently discontinue the Health Care Plan coverage option or any cash subsidy for retirees at any time, with or without prior notice. No vested or accrued right to such coverage shall be deemed to have arisen because it is part of this benefit program at the present time, and there shall not be deemed to be any right to receive this coverage as a consequence of your status as a past employee. In the event that Health Care Plan coverage for retirees is terminated without being replaced with comparable benefits, retirees would be notified of the alternatives available, such as conversion or continuation privileges.

Effective January 1, 2015, eligible Retirees will receive a subsidy to be applied toward the monthly cost of health insurance under the Local #112 Sheet Metal Workers Health Care Plan. The subsidy will be an amount equal to \$10 for each pension credit accrued under the Sheet Metal Workers Local 112 Pension Plan. In lieu of this subsidy for health insurance coverage under the Local #112 Health Care Plan, you may elect a cash subsidy toward the cost of coverage under a government health insurance exchange or marketplace. This alternative is described below.

For example, if you have 30 pension credits, you will receive a \$300 per month subsidy toward health insurance under the Local #112 Health Care Plan. You must pay the balance of the monthly premium. Please note that this offer of retiree coverage overlaps the COBRA period of coverage.

The subsidy is only available to you if you are an eligible Retiree enrolled in the Local #112 Health Care Plan, and only until you attain age sixty-five (65), at which time Retiree coverage will terminate. Your Spouse (as of the Retiree's retirement date) will also be eligible to maintain Retiree Coverage on a self-paid basis for a period of 36 months, or until your Spouse attains age sixty-five (65) if sooner.

The Retiree Coverage subsidy is available to any individual who was covered under the Local 112 Health Care Plan at retirement or was covered for a minimum of 60 months out of the 84 month period prior to retirement. Time spent working on a full-time basis for the Sheet Metal Workers International Union or a National or Regional Fund of another Sheet Metal Union – related entity will be considered coverage under the Health Care Plan. Anyone returning from employment with the Sheet Metal Workers International Union or other Sheet Metal Union – related entity must reapply for coverage hereunder within 30 days of terminating such employment.

If you, or your Spouse, terminate Retiree Coverage at any time prior to attainment of age sixty-five (65), you, or Spouse, will not ever thereafter be eligible to re-establish Retiree Coverage under the Plan. However, if Retiree Coverage is terminated because you have returned to Covered Employment and thereby qualified for active coverage, you may, upon a subsequent retirement, re-establish Retiree Coverage.

All benefits under the Retiree Coverage provision of the Plan are furnished through group health benefits contracts. Further information on the benefits available under Retiree Coverage is contained in the plan description booklets from the respective benefit companies. You should review this information in order to fully understand the level of benefits in force under Retiree Coverage.

Retiree Coverage available under this Plan will be secondary to any other coverage or benefits available to you.

If you are disabled and qualify for Social Security Disability benefits, Retiree Coverage will be available to you only until (a) you become eligible for Medicare or (b) the end of the 36th month from the onset of disability, whichever comes sooner.

When you are otherwise entitled to extended or continued coverage as a result of eligibility earned while an active Participant, benefits otherwise available will not be reduced. In such cases, the Plan's rules and benefits will be continued in force with respect to an affected Retiree, but only until such time as the accrued eligibility of the Retiree otherwise terminates.

Cash Subsidy Alternative

In lieu of maintaining coverage through the Sheet Metal Workers Local 112 Health Care Plan, you may elect to receive a reimbursement of premiums for health insurance purchased on the new health care exchanges, up to the amount of the subsidy, to age 65. This would be a one-time election. If a retiree waives coverage under the Plan, you may not return to coverage.

You have the right to opt out of the subsidy if you determine that the premium tax credit available under the exchange is worth more than the subsidy.

If you waive coverage under the Local 112 Health Care Plan, your subsidy will be credited to a Retiree Health Reimbursement Arrangement for each 12 calendar month period that you provide proof of coverage through the health care exchange.

This cash subsidy is only available to you if you otherwise qualify for the Retiree subsidy above.

SECTION 6

LEGAL RIGHTS, PRIVACY AND OTHER INFORMATION

1. **Rights Under ERISA.** As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). ERISA provides that all Plan participants shall be entitled to:

- (a) **Receive Information About Your Plan and Benefits.** Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit 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.

- (b) **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.
- (c) **Prudent Actions by Plan Fiduciaries.** In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer,

your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

- (d) **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 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 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.

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

2. **Qualified Medical Child Support Orders.** The Plan provides medical benefits in accordance with the requirements of ERISA. A Qualified Medical Child Support Order is any judgment, decree, or order (including approval of a property settlement agreement) issued by either a court of competent jurisdiction or through an administrative ruling that has the force and effect of state law which:

- (a) Relates to the provision of child support with respect to the Child of an Employee or COBRA Beneficiary under this Plan or provides for health benefit coverage to

such a Child, and is made pursuant to a state domestic relations law (including a community property law), and relates to such coverage under this Plan, or

- (b) Enforces a law relating to medical child support described in Section 1908 of the Social Security Act with respect to this Plan, and which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to receive benefits payable with respect to a beneficiary under this Plan. For purposes of this section, an "alternate recipient" shall mean any Child of an Employee or COBRA Beneficiary who is recognized by a Qualified Medical Child Support Order as having a right to enrollment under a group health plan with respect to such an Employee or COBRA Beneficiary, and
- (c) Satisfies the requirements of Section 609 of ERISA.

A procedure has been established to determine if a Qualified Medical Child Support Order exists. You may obtain a copy of the procedure at no charge from the Plan Administrator.

3. **Newborns' and Mothers' Health Protection Act.** Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your Plan Administrator.

4. **Women's Health and Cancer Rights Act.** Under this Federal law, group health plans that provide medical and surgical benefits for mastectomies must provide coverage in connection with the mastectomy, in the manner determined by the attending physician and the patient for:

- (a) Reconstruction of the breast on which the mastectomy was performed, or
- (b) Surgery and reconstruction of the other breast to produce a symmetrical appearance, or
- (c) Prostheses and treatment of physical complications at all stages of mastectomy, including lymphedema.

Group health plans and health insurers may not deny eligibility to enroll, renew or continue group health plan coverage to avoid providing coverage for breast reconstruction or mastectomy complications. Further, the law prohibits:

- (a) Penalizing or otherwise reducing or limiting the reimbursement of an attending Provider for the required care, or
- (b) Providing any incentive (monetary or otherwise) to induce the attending Provider to provide care that would be inconsistent with the law.

The above-described coverage required by the law may only be subject to the annual deductibles, Copayments, and Coinsurance provisions that apply to similar benefits.

5. **HIPAA Compliance.** The Board of Trustees is the Plan Sponsor. Employees of the Trust Fund have access to the individually identifiable health information of Plan participants for administration functions of the Plan. When this health information is provided from the Plan to the Plan Sponsor, it is Protected Health Information (PHI) and, if it is transmitted by or maintained in electronic media, it is Electronic PHI.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Plan Sponsor's ability to use and disclose PHI and Electronic PHI. The following HIPAA definitions of PHI and Electronic PHI apply to this plan amendment:

Protected Health Information (PHI). Protected Health Information (PHI) means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe that the information can be used to identify the individual. Protected health information includes information of persons living or deceased.

Electronic Protected Health Information. Electronic Protected Health Information (Electronic PHI) means Protected Health Information that is transmitted by or maintained in electronic media.

The Plan Sponsor will have access to PHI and Electronic PHI from the Plan only as permitted under this Summary Plan Description or as otherwise required or permitted by HIPAA. Those instances where the Plan Sponsor may be provided PHI include:

- (a) Permitted Disclosure of Enrollment/Disenrollment Information

The Plan may disclose to the Plan Sponsor information on whether the individual is participating in the Plan.

- (b) Permitted Uses and Disclosure of Summary Health Information

The Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose Summary Health Information to the Plan Sponsor, provided that the Plan Sponsor requests the Summary Health Information for the purpose of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending, or terminating the Plan.

“Summary Health Information” means information (1) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under the Plan; and (2) from which the information described at 42 CFR §164.514(b)(2)(i) 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR § 164.514(b)(2)(i)(B) 42 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

(c) Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes

Unless otherwise permitted by law, and subject to the conditions of disclosure described below in paragraph 5 and obtaining the written certification of the Plan Sponsor, the Plan may disclose PHI and Electronic PHI to the Plan Sponsor, provided that the Plan Sponsor uses or discloses such PHI and Electronic PHI only for Plan administration purposes. “Plan administration purposes” means administration functions performed by the Plan Sponsor on behalf of the Plan, such as quality assurance, claims processing and appeals, auditing, and monitoring. Plan administration functions do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor or any employment-related actions or decisions.

Plan administration shall also include the filing of a claim with the Department of Health and Human Services (“HHS”) under the retiree reinsurance program established pursuant to Section 1102 of the Patient Protection and Affordable Care Act. The Plan shall disclose to the Secretary of HHS, on behalf of the Plan Sponsor, at such time and in such manner specified by the Secretary in guidance, information, data, documents, and records necessary for the Plan Sponsor to comply with the requirements of the program.

Notwithstanding any provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI or Electronic PHI in a manner that is inconsistent with 45 CFR §164.504(f) 45 CFR §164.504(f).

Conditions of Disclosure for Plan Administration Purposes. The Plan Sponsor agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR § 164.508 45 CFR § 164.508, which are not subject to these restrictions) disclosed to it by the Plan (or a health insurance issuer or HMO on behalf of the Plan), Plan Sponsor shall:

- not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;
- ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;

- not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- report to the Plan any use or disclosure of the PHI of which it becomes aware that is inconsistent with the uses or disclosures provided for;
- make available PHI to comply with HIPAA's right to access in accordance with 45 CFR §164.524 45 CFR §164.524;
- make available PHI for amendment, and incorporate any amendments to PHI, in accordance with 45 CFR § 164.526 45 CFR § 164.526;
- make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528 45 CFR § 164.528;
- make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;
- if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- ensure that the adequate separation between Plan and Plan Sponsor (i.e., the firewall), required by 45 CFR § 504 45 CFR § 504(f)(2)(iii), is established.

Plan Sponsor further agrees that if it creates, receives, maintains, or transmits any Electronic PHI (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508 45 CFR §164.508, which are not subject to these restrictions) on behalf of the Plan, it will:

- implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- ensure that the adequate separation between the Plan and Plan Sponsor (i.e., the firewall), required by 45 CFR § 504(f)(2)(iii) 45 CFR § 504(f)(2)(iii) is supported by reasonable and appropriate security measures;
- ensure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and
- report to the Plan any security incident of which it becomes aware, as follows: Plan Sponsor will report to the Plan, with such frequency and at such times as agreed, the

aggregate number of unsuccessful, unauthorized attempts to access, use, disclose, modify, or destroy Electronic PHI or to interfere with systems operations in an information system containing Electronic PHI; in addition, Plan Sponsor will report to the Plan as soon as feasible any successful unauthorized access, use, disclosure, modification, or destruction of Electronic PHI or interference with systems operations in an information system containing Electronic PHI.

Adequate Separation Between Plan and Plan Sponsor. The Plan Sponsor shall allow Trust Fund employees access to the PHI. No other persons shall have access to PHI. These employees shall only have access to and use of PHI to the extent necessary to perform the plan administration functions needed for successful operation of the Plan. In the event that any of these specified employees does not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's employee discipline and termination procedures.

The Plan Sponsor shall ensure that the provisions of this paragraph 6 are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain, or transmit Electronic PHI on behalf of the Plan.

6. **Service of Legal Process.** The Trustees have designated an agent to accept service of legal papers. Process can be served upon the Plan by directing such legal service to:

Plan Administrator
1200 Clemens Center Parkway
P.O. Box 1146
Elmira, New York 14902-1146

or to any Trustee or to the Board of Trustees.

7. **Plan Interpretations, Determinations, and Amendments.** Notwithstanding any other provisions of this document, the Board of Trustees, or their designee, shall have exclusive authority and discretion to:

- (a) determine whether an individual is eligible for any benefit under this Plan;
- (b) determine the amount of benefits, if any, an individual is entitled to from this Plan;
- (c) determine or find facts that are relevant to any claim for benefits from this Plan;
- (d) interpret all of this Plan's provisions;
- (e) interpret all the provisions of the Summary Plan Description booklet;
- (f) interpret the provisions of any collective bargaining agreement or written participation agreement involving or impacting the Plan;

- (g) interpret the provisions of the Trust Agreement governing the operation of this Plan;
- (h) interpret all the provisions of any other document or instrument involving or impacting this Plan; and
- (i) interpret all the terms used in this Plan, the Summary Plan Description Booklet, and all of the other previously mentioned Agreements, documents, and instruments.

All such determinations and interpretations made by the Trustees, or their designee shall be final and binding upon any individual claiming benefits under the Plan, upon all Employees, all Employers, the Union and any party who has executed an Agreement with the Trustees or the Unions; shall be given deference in all courts of law, to the greatest extent allowable by applicable law, shall not be overturned or set aside by any court of law unless the court finds that the Trustees, or the designee, abused their discretion in making such determination or rendering such interpretation.