



National Automatic Sprinkler
Metal Trades
Welfare Fund

2014

Plan Document
and
Summary Plan Description

For Additional Information and Assistance Contact the Fund Office

National Automatic Sprinkler Metal Trades
Welfare Fund
8000 Corporate Drive
Landover, MD 20785

Telephone Assistance: 301-577-1700

Toll Free Number for:

Benefits Verification or Assistance: 800-638-2603

To Certify Hospital Admissions: 866-343-3709

Medical PPO Provider Finder 800-810-BLUE

Express Scripts Mail Order Prescription: 866-544-6775

Internet www.nasifund.org

This booklet is both the Summary Plan Description and the Plan Document for the National Automatic Sprinkler (“NAS”) Metal Trades Welfare Fund plan of benefits. Interpretations regarding eligibility for benefits, claims, status of employees and employers, or any other matter relating to the Welfare Fund should only be obtained through the full Board of Trustees or the Fund Administrator. The Trustees are not obligated by, responsible for, or bound by opinions, information or representations from other sources.

The Board of Trustees has fully discretionary authority to interpret the Plan and decide all issues pertaining to the Plan. Additionally, the Board of Trustees may, in its sole discretion, amend or terminate the Plan and any of its provisions, including classes of coverage, eligibility and requirements for coverage, availability, nature and extent of benefits and conditions and methods of payment.

Dear Member:

We are pleased to provide you with this updated summary of your plan of benefits. You have received this booklet based on your work in employment covered by the Plan. However, you must satisfy the eligibility requirements shown on the following pages in order to qualify for benefits. Since the purpose of the Welfare Fund is to benefit you and your family, we urge you to read this booklet carefully so that you will understand the complete plan of benefits, as well as the eligibility rules and the procedures for filing claims. You can also find the text of this booklet on the internet at www.nasifund.org.

The Trustees strive to provide the most appropriate benefits that will contribute to the security, health and well-being of the Union membership. Changing economic conditions require a constant assessment of the benefit plan to maintain its financial stability.

Please remember that you have the right to submit to the Trustees for their consideration any questions or concerns in connection with the operation or administration of the Plan.

Sincerely,

BOARD OF TRUSTEES

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I. Eligibility

Plan Eligibility

The National Automatic Sprinkler Metal Trades Welfare Plan offers three Plans of Benefits (Plan A, Plan B, and Plan C) for all active eligible employees. If you are an active eligible employee, the benefit schedule that applies to you depends on the contribution rate negotiated under the Collective Bargaining Agreement (see Definitions, page 58) and the hours you work for that employer. Such work is called "covered employment." In determining your eligibility for benefit coverage, the Fund does not credit hours of covered employment unless and until the contributions are actually received.

Eligibility is based on monthly contribution reports of hours worked submitted by your employer. Contribution reports with hours worked are not due in, and therefore are not processed by the Fund Office, until late in the following month. The Fund Office, therefore, cannot certify in advance when benefits will start or end. Notices are sent out as soon as eligibility can be determined. You should keep track of your hours worked each month. The Fund Office can then advise you what your eligibility might be. However, the final determination of eligibility is based upon the contributions actually received.

Your Plan of Benefits depends upon the contribution rate in your collective bargaining agreement. The Trustees of the Plan announce the required rates for Plan A, B and C each spring, and they become effective as of September 1st of that year. You will receive Plan A or Plan B benefits as of that date if your contribution rate is sufficient. All employees who do not qualify for Plan A or Plan B may be placed in Plan C until rates are increased, or the collective bargaining agreement terminates, or your employer's participation in the Plan is terminated by the Plan's Trustees.

Who is Eligible

Eligibility for Employees

Eligibility is based upon hours worked under the Collective Bargaining Agreements which obligate employers to report and pay contributions to this Fund on your behalf, and for which contributions have been received.

Individual contributions to gain or maintain eligibility are not allowed. Under the circumstances described in "Continuation Coverage," individuals may pay COBRA premiums to purchase continued health coverage.

Hours are not credited and, therefore, eligibility is not granted unless the contributions are actually received. In addition, hours will be credited if you are on a leave of absence under the provisions of the Family and Medical Leave Act of 1993.

The Family and Medical Leave Act ("FMLA") of 1993 entitles employees eligible under the Act to take up to 12 weeks of unpaid job-protected leave each year due to the employee's own illness; or to care for a seriously ill child, spouse or parent; the birth or placement of a child with the employee in the case of adoption or foster care or a "qualifying exigency" as defined in applicable regulations arising out of the fact that a covered family member is on active duty or called to active duty status in the National Guard or Reserves in support of a federal contingency operation. In addition, the FMLA, provides that an eligible Employee who is a qualifying family member or next of kin of a covered military service member is able to take up to 26 workweeks of leave in a single 12 month period to care for the covered service member with a serious illness or injury incurred in the line of duty.

Employees eligible for leave under the FMLA are those who have been employed at least 12 months by the employer and who have provided at least 1,250 hours of service to the employer. An employee at a work site at which there are fewer 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 employee equals or is greater than 50. Contact the Fund Office if you are planning to take FMLA leave so that the Fund is aware of your employer's responsibility to report the period of your absence. In addition, if you have any questions about the FMLA, you should contact your employer or the nearest office of the Wage and Hour Division, listed in most telephone directories under U. S. Government, Department of Labor, Employment Standards Administration.

Eligibility is based on payroll reports, with monthly cutoff dates determined by each employer. Contribution reports with hours worked are not due and processed until late in the following month. The Fund Office, therefore, cannot certify in advance when benefits will start or end. Notices are sent as soon as eligibility can be determined.

All employees should keep track of the hours they work each month. The Fund Office can advise you of your eligibility status if you have a record of your hours worked. However, the final determination of eligibility will be based upon contributions actually received by the Fund Office.

Initial Eligibility for Employees Covered by a Collective Bargaining Agreement

You become eligible for benefits on the first of the month after you are credited with a total of 600 hours of work under a Collective Bargaining Agreement or a participation agreement, within a period of no more than six (6) consecutive months.

However, if you become Totally Disabled (see Definitions, page 61) before you establish your initial eligibility for benefits, a period of up to one year during which you are Totally Disabled will not be counted in determining the six-consecutive-month period for gaining initial eligibility. In other words, the months before and after your period of Total Disability will be treated as if they are consecutive.

In addition, for purposes of satisfying the Initial Eligibility hours requirement only, you will be credited with your hours worked for up to three (3) months under a Collective Bargaining

Agreement or participation agreement for which your employer is required to contribute but has not done so. You must provide documentation acceptable to the Trustees of your actual hours worked. In order to become eligible under this special rule, you must be working for a non-delinquent employer on the date of your eligibility.

If you or one of your eligible dependents is confined in a Hospital (see Definitions, page 59) or Disabled on the day you become eligible, benefits are payable from the date you become covered for all services rendered from that date.

If you work in employment covered by this Plan and before you become eligible for benefits, become employed in work covered by the National Automatic Sprinkler Industry Welfare Plan, the contributions for hours you worked in employment covered by this Plan may be transferred to the National Automatic Sprinkler Industry Welfare Fund and the hours credited toward your initial eligibility in that Plan. Similarly, if you work in employment covered by the National Automatic Sprinkler Industry Welfare Plan and before you become eligible for benefits, become employed in work covered by this Plan, the contributions for hours you worked in employment covered by the National Automatic Sprinkler Industry Welfare Plan may be transferred to this Fund and the hours credited toward your initial eligibility in this Plan. The contributions and hours will not be transferred automatically; you must request the transfer in writing. The transfer may be requested by letter or e-mail.

Special Eligibility Rules When a New Shop is Organized

When a new shop is organized and begins participation in this Plan, the Board of Trustees may establish special eligibility rules for benefits previously available from insurance carriers. The purpose of these special eligibility rules is to prevent breaks in benefit coverage for employees. If special eligibility rules are established, they only apply to employees who were actively at work the first month the employer joined the Plan and who were eligible for benefits under the prior insurance policy in the immediately preceding month.

Reinstatement

During the first 12 months after losing eligibility, you will be eligible again on the first of the month after two consecutive months in which you are credited with a total of 80 or more hours of work, provided that you have remained available for work covered by the Plan as verified by your Local Union. After 12 months of ineligibility, you must again qualify under the Initial Eligibility rule.

For purposes of reinstatement only, in calculating the 12-month period, the Fund will consider hours you worked for which contributions were required but not paid to the Fund. Your reinstatement must still be based on hours you have worked for which contributions have been received.

Termination of Eligibility

Termination of Eligibility for Active Employees

Eligibility for benefits will terminate on:

- the last day of the fourth month following the last two consecutive months in which you are credited with 80 or more hours of work with at least one hour in the second of those two months ("Continuing Eligibility period"), or if earlier,
- the date that you cease to be available for work covered by the Plan as verified by your Local Union.

This termination date is extended if you are Disabled. These extensions are described below in the sections entitled "Disability Extension" and "Total Disability Extension".

Eligibility During and After Periods of Uniformed Service

When You Leave: If you enter the Uniformed Services as defined in the Uniformed Services Employment and Reemployment Rights Act (USERRA) for active military duty or training, inactive duty or training, full-time National Guard or Public Health Service duty, or fitness-for-duty examination, and you otherwise meet the requirements of USERRA (see below), coverage for you and your eligible dependents will terminate under the termination of eligibility rule for active employees as stated above, as if you remained available for employment. For example, if you are eligible for benefits and leave covered employment for active military duty, your family eligibility will terminate on the last day of the fourth month following the last two consecutive months in which you are credited with 80 or more hours of work with at least one hour in the second of those two months. You may then self-pay for continuation coverage for the lesser of 24 months or the remaining period of qualified uniformed service under the procedures set forth below for COBRA Continuation Coverage. You must make that election within 60 days of the date your coverage would otherwise terminate.

When You Return: If you are discharged other than dishonorably from Uniformed Service and you otherwise meet the requirements of USERRA (see below), Plan coverage for you and your eligible dependents will be reinstated on the day you return to work in Covered Employment. You and your eligible dependents will be eligible for a period immediately following your return to Covered Employment that is the same as your period of eligibility after the date that you left Covered Employment to enter the Uniformed Services described above. At the end of that period of eligibility, if you have not yet worked sufficient hours in Covered Employment to again meet the requirements for Continuing Eligibility, you may then self-pay for continuation coverage under the procedures set forth below for COBRA Continuation Coverage. You must make that election within 60 days of the date your coverage would otherwise terminate. You may continue to self-pay at the COBRA rate until you again meet the requirements for Continuing Eligibility or until the maximum period of COBRA Continuation Coverage is reached, whichever first occurs.

Requirements of USERRA: The requirements of USERRA that you must meet to be covered by this section include:

- You (or an appropriate military officer) must give advance written or oral notice to the employer that you are entering uniformed service (unless such advance notice is impossible, unreasonable or precluded by military necessity);
- You must not be dishonorably discharged upon the conclusion of the uniformed service;
- The cumulative length of all of your absences with the employer due to uniformed service must generally be no longer than five years.
- Upon leaving the uniformed service, you must you must report back to your pre-service employer for reemployment and/or report to your local union for a referral to Covered Employment within the following specified periods of time:
 - Uniformed service of less than 31 days, or for any length for a fitness for duty examination -- you must generally report for work on the first regularly-scheduled workday at least 8 hours after you arrive home from service.
 - Uniformed service of more than 30 days, but less than 181 days -- you must generally report for work within 14 days after completion of service.
 - Uniformed service of more than 180 days -- you must report for work within 90 days after completion of the service.

If You Are Disabled

When an employee eligible for benefits becomes Disabled, benefits are extended while the Disability (see Definitions, page 59) continues as outlined below. Please note those situations where eligibility is automatic and those where notice must be filed with the Fund. The Plan does not provide medical coverage for on-the-job injuries whether or not such injuries are deemed compensable by workers' compensation.

Disability Extension

An employee who becomes Disabled while eligible for benefits may extend eligibility for up to four additional months while the Disability continues. Regular benefits will continue for you and your eligible dependents. In no event can your eligibility be longer than eight months from the last two consecutive months in which you worked 80 or more hours with at least one hour in the second of these two months.

The extension is not available to employees who cease to be available for work covered by the Plan as verified by their Local Union.

If you qualify for and are receiving Weekly Disability Income Benefits, the extension is automatic while you are receiving benefits. Otherwise, you must provide satisfactory evidence of your Disability to the Fund Office.

Disability is defined as the inability to perform work in the Sprinkler Industry. In addition, you must not receive any substantial compensation related to any employment, and you must be under the regular care of a Physician who certifies the Disability. Evidence of on-the-job workers' compensation as well as off-the-job Disabilities or illness may be used to qualify for Disability coverage. It is not the responsibility of your Physician, employer, workers' compensation insurance company, Business Manager or Business Agent to submit evidence of your Disability to the Fund Office, although they may assist you. During this period, the Fund has the right to request evidence of continuing Disability and may require you to have a physical examination by a Physician chosen and paid for by the Fund. Benefits are terminated when you become eligible for Medicare or when you recover from the Disability.

Total Disability Extension

If you qualify for a Social Security Disability Award and file the award with the Fund Office within six months of receipt, benefits may be restored or continued depending on the date of Disability shown on your Award. The Fund may request evidence of your continuing eligibility for a Social Security Disability Award.

If the effective date of Disability shown on the Award is during the period you were eligible for benefits (including the Disability extension), benefits are restored retroactively to that date. If the date is during or after the period you were on the 12-month additional coverage for Disabled employees, no benefits apply.

Benefits include dependent coverage and all active employee benefits (except dependent life insurance, Accidental Death and Dismemberment, or Weekly Disability Income Benefits). Life insurance coverage terminates whenever you recover or when you reach age 61.

If benefits are terminated and then restored retroactively, and if during the period of termination you obtained individual insurance protection for yourself or dependents eligible for retroactive benefits, this Plan will reimburse you for amounts actually paid for insurance premiums and any difference in deductibles between this Plan and your other insurance. This Plan will not reimburse you for premiums paid for other group coverage. Non-bargaining unit employees and office employees are not eligible for the Disability extension unless initially eligible for health benefits under a Collective Bargaining Agreement.

Coverage for Disabled Employees or Dependents

You can retain Comprehensive Medical and Substance Abuse coverage for up to 12 additional months if you (or your dependent) are Disabled when termination of eligibility would normally occur. Coverage applies only to you (the Disabled employee) or your Disabled dependent and not to other family members.

During this period, the Fund has the right to request evidence of continuing Disability and may require you to have a physical examination by a Physician chosen and paid for by the Fund. Benefits are terminated at the end of the 12 months or, if earlier, upon recovery from the Disability.

If the employee entitled to coverage under this provision of the Plan recovers from the Disability and returns to employment covered by the Fund, the employee and his or her dependents will be eligible for benefits as of the date of the employee's return to work and for the following calendar month. In order for eligibility to continue beyond this period, the employee must satisfy the requirements for Reinstatement on page 3. The employee must promptly notify the Fund in writing of his or her return to work.

Termination of Disability Coverage

Benefits will continue until the date you recover or qualify for Medicare coverage, but not longer than 29 months from the last two consecutive months in which you worked 80 or more hours with at least one hour in the second of those two months. Life insurance continues as explained above.

Dependent Eligibility

Your eligible dependents include:

1. Your spouse;
2. Your biological or legally-adopted child, or child legally placed with you for adoption, your stepchild or legally- placed foster child from Enrollment until the end of the month in which the child attains age 26;
3. Your unmarried "other" child. An unmarried "other" child includes a grandchild or any other child who lives with you in a parent-child relationship, who depends on you for more than one-half of his or her financial support, and for whom you have a legal obligation to provide health care. Your "other" child is covered from Enrollment until the end of the calendar month in which the child reaches 19 years of age.

In the event both your grandchild and your child who is a parent of your grandchild live with you, both must depend on you for at least 50% of their financial support for the grandchild to be considered an eligible dependent. As noted above, your child (the parent of your grandchild) may be an eligible dependent without regard to whether you provide financial support to your child.

Your unmarried "other" child who is over age 18, can be considered an eligible dependent if at least one of the following applies:

- your unmarried “other” child is a full-time student(s) in an accredited school or college, in which case dependent status will continue until the end of the calendar month in which the child reaches 23 years of age provided that he or she either (a) lives with you for more than one-half of the year and does not provide more than one-half of his or her own support or (b) depends on you for more than one-half of his or her financial support;
- Your unmarried “other” child who otherwise satisfies the eligibility criteria of a full-time student as stated above immediately before taking a “medically necessary leave of absence” from a postsecondary educational institution. Eligible dependent status under this section will continue until the earlier of (a) one year after the first day of the medically necessary leave of absence or (b) the date coverage would otherwise terminate under the terms of the Plan. Coverage will only apply under this section if the Plan has received written certification by a treating physician of the “other” child stating that the “other” child is suffering from a serious illness or injury and that the leave of absence or change in enrollment status is medically necessary. A “medically necessary leave of absence” means a leave of absence or any other change in enrollment of the child at such institution, such as a change to part-time student status, that begins while the child is suffering from a serious illness or injury that is medically necessary as certified by the treating physician, and that causes such child to lose student status for purposes of continued eligibility under the Plan; or
- Your unmarried “other” child who is a part-time student(s) in an accredited school or college, provided that the child is unable to attend school or college on a full-time basis because of a disabling condition that began while the child was covered by this Plan, until the end of the calendar month in which the child reaches 23 years of age, and provided that the child depends on you for more than one-half of his or her financial support. Satisfactory documentation of disability must be supplied to the Fund office.

For purposes of determining dependent eligibility, the terms “full-time and part-time student” are defined by the standard established by the students’ school or college.

4. Your biological or legally-adopted child, or child legally placed with you for adoption, your stepchild or legally- placed foster child, or your “other” child, who is unmarried, dependent upon you for financial support, and incapable of self-support because of a physical or mental Disability that occurred while an eligible dependent prior to age 26 (prior to age 19 in the case of an “other” child). The eligibility for the child will continue as long as the child continues to be incapable of earning a living due to the physical or mental disability, and the child either (a) is permanently and totally disabled, lives with you for more than one-half of the year and does not provide more than one-half of his/her own support or (b) depends on you for more than one-half of his/her financial support. Proof of

incapacity must be submitted to the Fund Office prior to age 26 (prior to age 19 in the case of an “other” child) and may be required periodically thereafter.

5. Your child covered by Qualified Medical Child Support Orders (QMCSO), see page 17. However, if your child who is the subject of the QMCSO is not your “dependent” as defined in Internal Revenue Code §§ 105(b) or 152, you may be subject to income tax on the fair market value of the coverage provided to that child by the Plan under the terms of the QMCSO.

You must enroll your eligible dependents for coverage to become effective. See Enrollment, page 13.

If You Die While Eligible for Benefits

Should you die while eligible for benefits under the rules stated above, benefits for your dependents will be continued for 12 months from the last two consecutive months in which you worked 80 or more hours with at least one hour in the second of those two months.

Your spouse and dependents may be eligible for further benefits as explained under the Retiree Eligibility, see page 11 and Continuation Coverage rules (see page 13).

Termination of Dependent Coverage

Benefits for dependents end on the earliest of the following:

1. the date employee coverage terminates;
2. for your Spouse and any stepchildren, the date you and your Spouse are divorced;
3. the date that your “other” child marries. An “other” child who marries cannot regain dependent coverage;
4. the date your “other” child becomes eligible for employee benefits under this Plan;
5. the date that is 12 months after the expiration of a deceased employee's Continuing Eligibility Period (see "Termination of Eligibility for Employees");
6. on the last day of the month in which the dependent is no longer an eligible dependent; or
7. upon the employee's entry into military service.

Notification Requirement upon Divorce

In addition to the notice requirements under COBRA, you have an obligation to promptly notify the Fund Office in writing following a divorce. Unless COBRA is elected, the divorced spouse and children of the divorced spouse (step children of the participant) become ineligible for benefits upon the divorce. **If notice of the divorce is not provided to the Fund Office, and as a result, benefits are paid to an ineligible dependent, the Trustees may decide to recover those benefits by treating such benefits as an advance to you, and deducting such amounts from benefits which become due to you until the entire amount of benefits erroneously paid is recovered.**

Eligibility and Enrollment After Retirement

The coverage you and your dependents are eligible for once you retire is determined by the benefit schedule under which you had coverage while working in covered employment. This coverage consists primarily of Comprehensive Medical coverage and coverage for Alcoholism and Drug Abuse Benefits. If you qualify for coverage under Plan A, you also have coverage for Dental Care Benefits and Vision Care Benefits. There is no coverage after retirement under any of the Plans of Benefits for the Life Insurance Benefit, the Accidental Death and Dismemberment Benefit, or the Weekly Disability Income Benefit.

To be eligible for or to continue to be covered for benefits upon retirement, you must meet the requirements for retiree eligibility. Your dependents must also meet certain eligibility requirements for benefit coverage after you retire. If you are eligible for retiree coverage but not currently covered by this Plan, benefits will commence on the effective date of your pension from the National Automatic Sprinkler Metal Trades Pension Fund (called the "Pension Fund").

You should keep in mind when selecting the form of your pension payment that the continuation of benefits under this Plan for your spouse and other dependents after your death is based upon your spouse's eligibility for a survivor's benefit from the Pension Fund. Please note that the continuation of benefits for retired employees and their eligible dependents is determined by the continued participation in this Plan of your employer and your sprinkler local union, as well as the financial condition of this Fund.

If you refuse retiree coverage when first eligible or if you terminate existing retiree benefits, you are not allowed to re-enroll for retiree coverage at a later date.

Eligibility for Coverage at Retirement

Retiree Eligibility - You are eligible for coverage once you retire if you meet all of the following requirements:

1. you are receiving a monthly pension from the Pension Fund and you authorize the deduction from your pension check of the monthly premium for payment of coverage. (The amount of the premium is determined by the Board of Trustees and is adjusted

periodically. For coverage under Plan A, the current monthly premium is \$80.00. The monthly premium is \$75.00 for coverage under Plan B or C.);

2. you were eligible for coverage under this Plan for at least three out of the last five years before commencement of your pension from the Pension Fund; and
3. you were credited by this Fund with at least 500 hours of covered employment in the consecutive three-calendar-year period before the commencement date of your pension from the Pension Fund. (The consecutive three-calendar-year period includes the year in which you retire unless you retire on January 1.)

Dependent Eligibility - Your eligible dependents must meet the following additional requirements to receive coverage under this Plan once you retire and are eligible for coverage.

1. Your spouse must have been married to you for at least one year on the commencement date of your pension from the Pension Fund. (If you remarry and return to covered employment, your new spouse is not covered under this plan, should you retire again.)
2. Your dependent child must meet the requirements of an eligible dependent before you retire unless he or she is your newborn child or a child placed with you for adoption after you retire.

Retiree Coverage for Spouses Following the Death of an Active or Retired Employee

Active Employee - If you die while working in covered employment, your dependents are eligible for retiree benefit coverage under this Plan if all the following requirements are met:

1. you were eligible for coverage under this Plan in three out of the last five years before the date of your death;
2. this Fund credits you with at least 500 hours of covered employment during the consecutive three-calendar-year period ending with the year of your death;
3. your spouse qualified for survivor benefits from the Pension Fund and he or she agrees to the necessary pension reduction for premium payments for coverage under this Plan; and
4. your dependents meet all the other requirements for dependent eligibility.

Coverage begins following the termination of all continued or extended benefits for eligible dependents of active employees.

Retired Employees - If you die while covered for retiree benefits, your eligible dependents remain covered as long as your spouse is eligible for survivor's benefits from the Pension Fund and he or she agrees to the necessary pension reduction to cover the monthly premium payments.

Your dependents also must meet the additional requirements for dependent eligibility for retiree benefits.

Termination of Retiree Coverage

Your coverage under this Plan terminates on the earliest of:

1. the date you withdraw authorization for deductions from your pension of the monthly premium to pay for retiree benefit coverage;
2. the date you return to covered employment;
3. the date of your death;
4. the date the Fund or retiree coverage terminates.

Coverage for your eligible dependents terminates under this Plan on the earliest of:

1. the date your spouse loses eligibility for a survivor's benefit from the Pension Fund;
2. the date your spouse withdraws authorization for deductions from his or her survivor's benefit of the monthly premium required to pay for benefit coverage;
3. the date your spouse remarries;
4. the date your dependent child is no longer an eligible dependent;
5. the date the Fund terminates dependent or retiree coverage; or
6. the date the Plan terminates.

If you have coverage for retiree benefits and either you or your dependents drop this coverage, it is not possible to re-enroll at a future date. This rule does not apply to a retired employee who loses coverage as a result of his returning to covered employment.

Returning to Covered Employment

Your coverage for retiree benefits terminates on the date you return to covered employment or perform any work in any union or non-union building trades or metal trades industry. To receive further coverage under this Plan, you must meet the eligibility requirements for a new employee.

If you are a disability pensioner who recovers and returns to covered employment, you may continue to receive retiree coverage for up to six months after returning to work, if you pay the required premiums. (If you have not met the Plan's eligibility requirements for new employees by that time, your coverage (and that of your eligible dependents) under this Plan is terminated until you meet these requirements.)

When you return to retirement, you do not have to meet the requirement of working 500 hours in the consecutive three-calendar-year period before retirement to receive retiree coverage, if you were receiving this coverage during your previous retirement. However, if your retiree coverage was suspended because you worked in employment not covered by the Plan, retiree coverage will not be reinstated when you subsequently retire.

Enrollment

How to Enroll

In order for any benefits to be paid, it is necessary for all employees and dependents to be enrolled. You must enroll yourself and your dependents within 60 days of the date you gain eligibility under this plan. You should add new dependents within 60 days of certain life events such as the date of your marriage, the birth of your child, the placement of a child with you for adoption or as a foster child or within 60 days of the date an “other” child becomes your dependent. With your Enrollment Form, you are required to provide documents establishing your dependent’s status such as a proof of marriage or birth certificate. **If you fail to enroll yourself or any dependent (child or spouse) within this 60-day period, you will be able to enroll at any later date, but such later enrollment will provide benefits only for covered expenses that are incurred on or after the date of that later enrollment.**

Enrollment is done by completing an Enrollment Form and mailing it to the Fund Office along with the supporting documents. Enrollment Forms are provided to newly eligible employees whose address has been provided to the Fund office. Enrollment Forms are also available on the Fund’s website or by calling the Fund Office. Enrollment Forms may also be available from your employer or local union.

Important

You must report all changes in family status and maintain your current address with the Fund Office. You will be required to reimburse the Welfare Fund for any claim paid in error by the Fund Office because you have failed to update the enrollment status of your dependents. Important events that must be reported include your divorce or marriage.

Continuation of Coverage

If you or your dependents are eligible and make the proper applications and timely premium payments, coverage may be continued under the Plan's COBRA coverage.

COBRA Continuation Coverage

In certain circumstances in which coverage for benefits from this Plan would otherwise end because of certain events called “Qualifying Events”, you can pay to continue health coverage

for a limited period of time. This extended coverage is called COBRA Continuation Coverage. COBRA Continuation Coverage is available to you and your eligible dependents that are covered by this Plan on the day before the Qualifying Event – for example, the termination of employment that caused loss of Plan coverage. COBRA Continuation Coverage is also available to a child who is born or a child under age 18 who is placed for adoption with you while you are receiving COBRA Continuation Coverage.

You are responsible for paying the full cost of this coverage once all your coverage under this Plan ends. The COBRA rates are established by the Trustees and can change from time to time. COBRA Coverage does not include the Death Benefit, the Accidental Death and Dismemberment Benefit or the Weekly Disability Income Benefit.

If you elect and pay for COBRA Continuation Coverage when your eligibility terminates because your Employer has not paid the required contributions on your behalf, the Plan will reimburse all or a portion of your COBRA payments if the delinquent Employer contributions are collected and your eligibility is restored based on the contributions.

COBRA Rules for Employees

As an employee, you have the right to elect COBRA Continuation Coverage for yourself and/or for your spouse and/or for your eligible dependent children. Coverage can be continued for up to 18 months from the date you would lose coverage under the plan because you leave Covered Employment (for reasons other than gross misconduct) or because you do not have sufficient hours of Covered Employment for which contributions are received by the Fund to continue eligibility.

Under certain circumstances, a disabled person and his or her family may extend COBRA Continuation Coverage for up to a total of 29 months following termination of employment or a reduction in hours of employment. To qualify for the additional 11 months of coverage the disabled person must have a determination of disability from the Social Security Administration. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of coverage for this extension to apply. The determination from the Social Security Administration must be filed with the Plan within the later of 60 days of the date of the Social Security Disability determination, or the date of the Qualifying event, or the date the disabled person would lose coverage under the Plan, or the date the individual is informed of this notice requirement and procedure. The extended COBRA Continuation Coverage applies to the disabled individual and all covered non-disabled family members. See “Where to Send Notices and Information in Connection with COBRA Continuation Coverage” on page 17.

If an individual receives extended COBRA Continuation Coverage because of a disability, the disabled person must also notify the Plan within 30 days of a final determination by the Social Security Administration that the person is no longer disabled, or, if later, within 30 days of the date the individual is informed of this notice requirement and procedure. COBRA Continuation Coverage ends if Medicare coverage begins before the 29-month period expires or if the disabled

person recovers from the disability and has already received 18 months of COBRA Continuation Coverage.

COBRA Rules for Retired Employees

As described on pages 13-17, when your active employment under the Plan ends, you have the right to purchase COBRA Continuation Coverage for yourself and your spouse for up to 18 months (or 29 months if you don't qualify for the disability extension described above). If your active employment ends because you are retiring, you must choose between COBRA coverage for the limited period of time described above and on pages 13-17 or Retiree Coverage described on pages 10-12. You must reject the other type of coverage when you make this choice. If you choose Retiree coverage, you will not qualify for COBRA Continuation Coverage even if your Retiree coverage later terminates.

If your family experiences another qualifying event while receiving Retiree Coverage, the Spouse and dependent children in your family can get up to 36 additional months of Retiree Coverage as a COBRA benefit. This extension is available to your Spouse and dependent children if you die, become entitled to Medicare (Part A, Part B, or both), or you and your spouse get divorced, or if your dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose Retiree Coverage. In many cases, your spouse and/or dependent children will continue to qualify for Retiree coverage under other rules of the Plan.

COBRA Rules for Eligible Dependents

If you choose not to purchase COBRA Continuation Coverage, your spouse and/or eligible dependent children can separately purchase COBRA Continuation Coverage for themselves by making the election and the required monthly premium payments. The COBRA Continuation Coverage for dependents can be continued for up to 18 months (29 months if there is a disabled person electing coverage) if coverage would otherwise end because of the termination of the employee's Covered Employment or a reduction in the employee's hours of Covered Employment. However, coverage can be continued for up to 36 months for your spouse and eligible dependent children if their coverage would otherwise end because of:

- your death;
- your divorce from your spouse;
- your dependent child's loss of status as an eligible dependent under this Plan (see pages 8-9); or
- your entitlement to Medicare benefits.

If your family experiences another qualifying event while receiving COBRA Continuation Coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to

your spouse and dependent children if you die, become entitled to Medicare (Part A, Part B, or both), or you and your spouse get divorced, or if your dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Notification Requirements for COBRA Continuation Coverage

You or your spouse or your eligible dependent child must notify the Fund Office in writing within 60 days of a divorce or a child's loss of dependent status under the Plan. Your dependents should notify the Plan in writing within 60 days of your death. An employer must notify the Plan within 60 days of your death or eligibility for Medicare Benefits. The Plan will determine when your eligibility for benefits would end due to your termination of Covered Employment or the reduction in your hours of employment for which contributions are received by the Fund. See "Where to Send Notices and Information in Connection with COBRA Continuation Coverage" on page 17.

Following receipt of a notice from your dependent or employer, or after your loss of eligibility due to termination of Covered Employment or after a reduction in your hours of employment for which contributions are received by the Fund is determined, the Plan will notify you and your eligible dependents of your and/or your dependents' rights to purchase COBRA Continuation Coverage and the cost of the coverage.

Election of COBRA Continuation Coverage

You and each of your dependents have an independent right to elect COBRA Continuation Coverage. To elect COBRA Continuation Coverage, you and/or your spouse and/or your eligible dependent child must complete an election form provided by the Fund Office and submit it to the Fund Office within 60 days after the later of the date coverage would otherwise end or the date you, your spouse or eligible dependent child receives the notice of the right to elect COBRA Continuation Coverage. See "Where to Send Notices and Information in Connection with COBRA Continuation Coverage" on page 17.

Termination of COBRA Continuation Coverage

COBRA Continuation Coverage may terminate earlier than the maximum period (18, 29 or 36 months) if:

- all health benefits provided by the Plan terminate;
- you, your spouse or your eligible dependent child who has elected COBRA Continuation Coverage does not make the required payments to the Fund on time;
- you become covered under Medicare; or
- you, your spouse or your eligible dependent child becomes covered by another group health plan after the loss of coverage from this Plan unless that

replacement plan limits coverage due to pre-existing conditions, and the pre-existing condition limitation actually applies to you after your coverage under this Plan is taken into account.

Where to Send Notices and Information in Connection with COBRA Continuation Coverage

Notices and information concerning COBRA Continuation Coverage should be sent to:

Eligibility Department
NAS Metal Trades Welfare Fund
8000 Corporate Drive
Landover, MD 20785

301 577-1700

Questions concerning your COBRA Continuation Coverage rights should also be addressed to the Eligibility staff of the Fund office as indicated above.

Keep Your Plan Informed of Address Changes

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

Qualified Medical Child Support Orders

The Plan is required to recognize Qualified Medical Child Support Orders ("QMSCOs"). QMSCOs require health plans to recognize State court orders which the Plan finds to be Qualified Medical Child Support Orders, as defined in the Social Security Act, directing a participant's plan to provide health benefit coverage for dependent children under the age of 18, even if the Participant does not have custody of the children. If you have questions about QMSCOs, you should contact the Fund Office.

Certificate of Creditable Coverage

If you lose coverage under the Plan, the Fund will issue you a Certificate of Creditable Coverage showing how long you were covered under the Plan. You will receive the Certificate automatically when you lose coverage or become entitled to COBRA Continuation Coverage, and when your COBRA Continuation Coverage ceases. Also, you may request the Fund at any time to provide you with a Certificate within 24 months after losing coverage under the Plan.

Confidentiality and Protection of Your Health Information

The Fund will comply with the Standards for Privacy of Individually Identifiable Health Information promulgated by the Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 ("Privacy Rules"). Under these standards, the Fund will protect the privacy of individually identifiable health information and will block or limit the disclosure of this information to the Trustees, Employers, the Union, your family members, service providers and other third parties. Protected health information will be disclosed only (1) to the extent authorized by the patient; (2) as necessary for the administration of the plan, including the review and payment of claims and the determination of appeals; or (3) as otherwise authorized or required by law. The Fund has adopted certain written rules and policies to ensure that it complies with applicable law, with regards to its use, disclosure and maintenance of protected health information.

You may authorize the disclosure of your protected health information to third parties by signing a written authorization and submitting it to the Fund Office. You may also cancel any previous written authorization you have provided the Fund by submitting a written cancellation of authorization with the Fund Office. You may request these forms from the Fund Office.

The Fund has provided participants with a Notice of Privacy Practices for Protected Health Information. If you need a copy of the Notice or would like additional information about the Fund's use and disclosure of protected health information or your rights with regards to this information, you may request a copy of the Notice from the Fund Office.

II. Summaries of Benefits and Deductibles

PLAN A

For Eligible Employees and Retirees and Their Eligible Dependents

Comprehensive Medical Benefit:

If expenses are incurred "In-Network" through the PPO or if you live out of a PPO area, coverage is subject to the Deductible, then 70% of the next \$18,500.00 of Covered Expenses (see Definitions, page 58), then 100% of Covered Expenses thereafter, up to the Maximum Annual Medical Benefit.

- Deductible per calendar year, per person \$2,000
- Deductible per calendar year, per family \$4,000
- Out-of-pocket maximum, for an individual, each year (including Deductible) \$6,350
- Out-of-pocket maximum, for a family, each year (including Deductibles) \$12,700

If expenses are incurred "Out-of-Network" from someone other than a PPO service provider, coverage is subject to the Deductible, then 55% of the next \$15,888.88 of Covered Expenses (see Definitions, page 58), then 100% of Covered Expenses thereafter, up to the Maximum Annual Medical Benefit.

- Deductible per calendar year, per person \$2,500
- Deductible per calendar year, per family \$5,000
- Out-of-pocket maximum, for an individual, each year (not including Deductible) \$7,150
- Out-of-pocket maximum, for a family, each year (not including Deductibles) \$14,300

Comprehensive Medical Benefit includes:

- Chiropractic Care, limit 20 sessions per year
- Diagnostic Laboratory or Pathology Test and X-Ray
- Hospital Expenses, including inpatient care, room and board, and outpatient care such as emergency room services

- Hospice Care - Daily maximum \$150
 - Bereavement counseling, per session \$25
- Medical Care, including, but not limited to, Physicians' visits, ambulance service, rental of Durable Medical Equipment, visiting nurses
- Mental or Nervous Disorder Expenses
- Organ or Tissue Transplant
- Outpatient Substance Abuse Treatment Expenses subject to Comprehensive Medical Deductible, then 50% of Usual and Customary charges (the Plan only covers 50% of such outpatient expenses even after the Out-of-Pocket Maximum is reached)
- Surgical Expenses
- Second Surgical Opinion 100% of Usual and Customary charges

Prescription Drug Benefit:

60% coverage for preferred drugs and 50% coverage for nonpreferred drugs is provided through mail order and retail pharmacies. Brand coverage is limited to generic cost when generic is available. Maintenance drugs purchased at retail are subject to reimbursement limitation. Comprehensive Medical Out-of-Pocket maximum benefit does not apply to prescription drugs but a separate annual Out-of-Pocket maximum applies to prescription drugs in the amount of \$500

For Eligible Employees Only

- Death Benefit \$8,000
- Accidental Death Benefit \$8,000
- Accidental Dismemberment and Loss of Sight Benefit
 - Accidental Loss of both hands, feet, or sight of both eyes \$8,000
 - Accidental Loss of any combination of hand, foot, or sight of one eye \$8,000
 - Accidental Loss of speech and hearing in both ears \$8,000
 - Accidental Paralysis of arms and legs (quadriplegia) \$8,000
 - Accidental Brain Damage \$8,000
 - Accidental Loss of an arm or a leg \$6,000
 - Accidental Loss of one hand or foot or sight of one eye \$4,000
 - Accidental Paralysis of both legs (paraplegia) or of both limbs on one side of body (hemiplegia) \$6,000
 - Accidental Loss of speech \$6,000
 - Accidental Loss of hearing in both ears \$6,000
 - Accidental Paralysis of one arm or one leg \$2,000
 - Accidental Loss of thumb and index finger on same hand \$2,000

All losses resulting from one accident	\$8,000
All losses resulting from one accident	\$8,000
<ul style="list-style-type: none"> Weekly Disability Benefit for up to 26 weeks for the same Disability, per week 	\$150

For Eligible Employees and their Eligible Dependents

<ul style="list-style-type: none"> Death Benefit payable upon Death of Spouse or Dependent Child: <ul style="list-style-type: none"> - Spouse - Dependent Child (6 months to 19 years old) - Dependent Child (15 days to 6 months) 	<ul style="list-style-type: none"> \$2,000 \$1,000 \$200
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PLAN B

For Eligible Employee and Retirees and their Eligible Dependents

Comprehensive Medical Benefit:

If expenses are incurred "In-Network" through the PPO or if you live out of a PPO area, coverage is subject to the Deductible, then 70% of the next \$18,500.00 of Covered Expenses (see Definitions, page 65), then 100% of Covered Expenses thereafter, up to the Maximum Annual Medical Benefit.

- Deductible per calendar year, per person \$2,500
- Deductible per calendar year, per family \$5,000
- Maximum Annual Medical Benefit, per person for 2013 \$2,000,000
Unlimited after 2013
- Out-of-pocket maximum, for an individual, each year
(including Deductible) \$6,350
- Out-of-pocket maximum, for a family, each year
(including Deductibles) \$12,700

If expenses are incurred "Out-of-Network" from someone other than a PPO service provider, coverage is subject to the Deductible, then 50% of the next \$16,300.00 of Covered Expenses (see Definitions, page 58), then 100% of Covered Expenses thereafter, up to the Maximum Annual Medical Benefit.

- Deductible per calendar year, per person \$3,000
- Deductible per calendar year, per family \$6,000
- Out-of-pocket maximum, for an individual, each year
(not including Deductible) \$8,150
- Out-of-pocket maximum, for a family, each year
(not including Deductibles) \$16,300

Comprehensive Medical Benefit includes:

- Chiropractic Care, limit 20 sessions per year
- Diagnostic Laboratory or Pathology Test and X-Ray
- Hospital Expenses, including inpatient care, room and board, and outpatient care such as emergency room services

- Hospice Care - Daily maximum \$150
 - Bereavement counseling, per session \$25
- Medical Care, including, but not limited to, Physicians' visits, ambulance service, rental of Durable Medical Equipment, visiting nurses
- Mental or Nervous Disorder Expenses
- Organ or Tissue Transplant
- Outpatient Substance Abuse Treatment Expenses subject to Comprehensive Medical Deductible, then 50% of Usual and Customary charges (the Plan only covers 50% of such outpatient expenses even after the Out-of-Pocket Maximum is reached)
- Surgical Expenses
- Second Surgical Opinion 100% of Usual and Customary charges

Prescription Drug Benefit:

60% coverage for preferred drugs and 50% coverage for nonpreferred drugs is provided through mail order and retail pharmacies. Brand coverage is limited to generic cost when generic is available. Maintenance drugs purchased at retail are subject to reimbursement limitation. Comprehensive Medical Out-of-Pocket maximum benefit does not apply to prescription drugs but a separate annual Out-of-Pocket maximum applies to prescription drugs in the amount of \$500

For Eligible Employees Only

- Death Benefit \$8,000
- Accidental Death Benefit \$8,000
- Accidental Dismemberment and Loss of Sight Benefit:
 - Loss of both hands, feet, or sight of both eyes \$8,000
 - Loss of any combination of hand, foot, or sight of one eye \$8,000
 - Loss of one hand or foot or sight of one eye \$4,000
 - Sight of one eye \$4,000
 - All losses resulting from one accident \$8,000
- Weekly Disability Benefit for up to 26 weeks for the same Disability, per week \$150

For Eligible Employees and their Eligible Dependents

- Death Benefit payable upon Death of Spouse or Dependent Child:

- Spouse	\$2,000
- Dependent Child (6 months to 19 years old)	\$1,000
- Dependent Child (15 days to 6 months)	\$200

PLAN C

For Eligible Employee and Retirees and Their Eligible Dependents

Comprehensive Medical Benefit:

If expenses are incurred "In-Network" through the PPO or if you live out of a PPO area, coverage is subject to the Deductible, then 65% of the next \$18,500.00 of Covered Expenses (see Definitions, page 58), then 100% of Covered Expenses thereafter, up to the Maximum Annual Medical Benefit.

- Deductible per calendar year, per person \$2,500
- Deductible per calendar year, per family \$5,000
- Out-of-pocket maximum, for an individual, each year (including Deductible) \$6,350
- Out-of-pocket maximum, for a family, each year (including Deductibles) \$12,700

If expenses are incurred "Out-of-Network" from someone other than a PPO service provider, coverage is subject to the Deductible, then 50% of the next \$18,300.00 of Covered Expenses (see Definitions, page 58), then 100% of Covered Expenses thereafter, up to the Maximum Annual Medical Benefit.

- Deductible per calendar year, per person \$3,000
- Deductible per calendar year, per family \$6,000
- Out-of-pocket maximum, for an individual, each year (not including Deductible) \$9,150
- Out-of-pocket maximum, for a family, each year (not including Deductibles) \$18,300

Comprehensive Medical Benefit includes:

- Chiropractic Care, limit 20 sessions per year
- Diagnostic Laboratory or Pathology Test and X-Ray
- Hospital Expenses, including inpatient care, room and board, and outpatient care such as emergency room services
- Hospice Care - Daily maximum \$150
- Bereavement counseling, per session \$25

- Medical Care, including, but not limited to, Physicians' visits, ambulance service, rental of Durable Medical Equipment, visiting nurses
- Mental or Nervous Disorder Expenses
- Organ or Tissue Transplant
- Outpatient Substance Abuse Treatment Expenses subject to Comprehensive Medical Deductible, then 50% of Usual and Customary charges (the Plan only covers 50% of such outpatient expenses even after the Out-of-Pocket Maximum is reached)
- Surgical Expenses
- Second Surgical Opinion 100% of Usual and Customary charges

Prescription Drug Benefit:

60% coverage for preferred drugs and 50% coverage for nonpreferred drugs is provided through mail order and retail pharmacies. Brand coverage is limited to generic cost when generic is available. Maintenance drugs purchased at retail are subject to reimbursement limitation. Comprehensive Medical Out-of-Pocket maximum benefit does not apply to prescription drugs but a separate annual Out-of-Pocket maximum applies to prescription drugs in the amount of \$500

For Eligible Employees Only

- Life Insurance \$8,000
- Accidental Death Benefit \$8,000
- Accidental Dismemberment and Injury Benefit:
 - Accidental Loss of both hands, feet, or sight of both eyes \$8,000
 - Accidental Loss of both speech and hearing in both ears \$8000
 - Accidental Paralysis of arms and legs (quadriplegia) \$8000
 - Accidental Loss of one hand or foot or sight of one eye \$4000
 - Accidental Paralysis of both legs (paraplegia) or of both limbs on one side of body (hemiplegia) \$4000
 - Accidental Loss of speech or hearing in both ears \$4000
 - Accidental Paralysis of one arm or one leg (uniplegia) \$2000
 - Accidental Loss of thumb and index finger on same hand \$2000
 - All losses resulting from one accident \$8,000
- Weekly Disability Benefit for up to 26 weeks for the same Disability, per week \$150

For Eligible Employees and their Eligible Dependents

- Death Benefit payable upon Death of Spouse or Dependent Child:
 - Spouse \$2,000
 - Dependent Child (6 months to 19 years old) \$1,000
 - Dependent Child (15 days to 6 months) \$200

SCHEDULE FOR COBRA BENEFICIARIES OF PLAN A:

Comprehensive Medical Benefit:

If expenses are incurred "In-Network" through the PPO or if you live out of a PPO area, coverage is subject to the Deductible, then 70% of the next \$18,500.00 of Covered Expenses (see Definitions, page 58), then 100% of Covered Expenses thereafter, up to the Maximum Annual Medical Benefit.

- Deductible per calendar year, per person \$2,000
- Deductible per calendar year, per family \$4,000
- Maximum Annual Medical Benefit, per person for 2013 \$2,000,000
Unlimited after 2013
- Out-of-pocket maximum, for an individual, each year (not including Deductible) \$5,550
- Out-of-pocket maximum, for a family, each year (not including Deductibles) \$11,100

If expenses are incurred "Out-of-Network" from someone other than a PPO service provider, coverage is subject to the Deductible, then 55% of the next \$15,888.88 of Covered Expenses (see Definitions, page 58), then 100% of Covered Expenses thereafter, up to the Maximum Annual Medical Benefit.

- Deductible per calendar year, per person \$2,500
- Deductible per calendar year, per family \$5,000
- Maximum Annual Medical Benefit, per person for 2013 \$2,000,000
Unlimited after 2013
- Out-of-pocket maximum, for an individual, each year (not including Deductible) \$7,150
- Out-of-pocket maximum, for a family, each year (not including Deductibles) \$14,300

Comprehensive Medical Benefit includes:

- Chiropractic Care, limit 20 sessions per year
- Diagnostic Laboratory or Pathology Test and X-Ray
- Hospital Expenses, including inpatient care, room and board, and outpatient care such as emergency room services

- Hospice Care - Daily maximum \$150
 - Bereavement counseling, per session \$25
- Medical Care, including, but not limited to, Physicians' visits, ambulance service, rental of Durable Medical Equipment, visiting nurses
- Mental or Nervous Disorder Expenses
- Organ or Tissue Transplant
- Outpatient Substance Abuse Treatment Expenses subject to Comprehensive Medical Deductible, then 50% of Usual and Customary charges (the Plan only covers 50% of such outpatient expenses even after the Out-of-Pocket Maximum is reached)
- Surgical Expenses
- Second Surgical Opinion 100% of Usual and Customary charges

Prescription Drug Benefit:

60% coverage for preferred drugs and 50% coverage for nonpreferred drugs is provided through mail order and retail pharmacies. Brand coverage is limited to generic cost when generic is available. Maintenance drugs purchased at retail are subject to reimbursement limitation. Comprehensive Medical Out-of-Pocket maximum benefit does not apply to prescription drugs but a separate annual Out-of-Pocket maximum applies to prescription drugs in the amount of \$500

SCHEDULE FOR COBRA BENEFICIARIES OF PLAN B

Comprehensive Medical Benefit:

If expenses are incurred "In-Network" through the PPO or if you live out of a PPO area, coverage is subject to the Deductible, then 70% of the next \$18,500.00 of Covered Expenses (see Definitions, page 58), then 100% of Covered Expenses thereafter, up to the Maximum Annual Medical Benefit.

- | | |
|---|----------------------|
| • Deductible per calendar year, per person | \$2,500 |
| • Deductible per calendar year, per family | \$5,000 |
| Maximum Annual Medical Benefit, per person for 2013 | \$2,000,000 |
| | Unlimited after 2013 |
| • Out-of-pocket maximum, for an individual, each year
(not including Deductible) | \$5,550 |
| • Out-of-pocket maximum, for a family, each year
(not including Deductibles) | \$11,100 |

If expenses are incurred "Out-of-Network" from someone other than a PPO service provider, coverage is subject to the Deductible, then 55% of the next \$18,111.11 of Covered Expenses (see Definitions, page 58), then 100% of Covered Expenses thereafter, up to the Maximum Annual Medical Benefit.

- | | |
|---|----------------------|
| • Deductible per calendar year, per person | \$3,000 |
| • Deductible per calendar year, per family | \$6,000 |
| Maximum Annual Medical Benefit, per person for 2013 | \$2,000,000 |
| | Unlimited after 2013 |
| • Out-of-pocket maximum, for an individual, each year
(not including Deductible) | \$8,150 |
| • Out-of-pocket maximum, for a family, each year
(not including Deductibles) | \$16,300 |

Comprehensive Medical Benefit includes:

- Chiropractic Care, limit 20 sessions per year
- Diagnostic Laboratory or Pathology Test and X-Ray
- Hospital Expenses, including inpatient care, room and board, and outpatient care such as emergency room services

- Hospice Care - Daily maximum \$150
 - Bereavement counseling, per session \$25
- Medical Care, including, but not limited to, Physicians' visits, ambulance service, rental of Durable Medical Equipment, visiting nurses
- Mental or Nervous Disorder Expenses
- Organ or Tissue Transplant
- Outpatient Substance Abuse Treatment Expenses subject to Comprehensive Medical Deductible, then 50% of Usual and Customary charges (the Plan only covers 50% of such outpatient expenses even after the Out-of-Pocket Maximum is reached)
- Surgical Expenses
- Second Surgical Opinion 100% of Usual and Customary charges

Prescription Drug Benefit:

60% coverage for preferred drugs and 50% coverage for nonpreferred drugs is provided through mail order and retail pharmacies. Brand coverage is limited to generic cost when generic is available. Maintenance drugs purchased at retail are subject to reimbursement limitation. Comprehensive Medical Out-of-Pocket maximum benefit does not apply to prescription drugs but a separate annual Out-of-Pocket maximum applies to prescription drugs in the amount of \$500

SCHEDULE FOR COBRA BENEFICIARIES OF PLAN C

Comprehensive Medical Benefit:

If expenses are incurred "In-Network" through the PPO or if you live out of a PPO area, coverage is subject to the Deductible, then 70% of the next \$18,500.00 of Covered Expenses (see Definitions, page 65), then 100% of Covered Expenses thereafter, up to the Maximum Annual Medical Benefit.

- Deductible per calendar year, per person \$2,500
- Deductible per calendar year, per family \$5,000
- Maximum Annual Medical Benefit, per person for 2013 \$2,000,000
Unlimited after 2013
- Out-of-pocket maximum, for an individual, each year
(not including Deductible) \$5,550
- Out-of-pocket maximum, for a family, each year
(not including Deductibles) \$11,100

If expenses are incurred "Out-of-Network" from someone other than a PPO service provider, coverage is subject to the Deductible, then 55% of the next \$20,333.33 of Covered Expenses (see Definitions, page 65), then 100% of Covered Expenses thereafter, up to the Maximum Annual Medical Benefit.

- Deductible per calendar year, per person \$3,000
- Deductible per calendar year, per family \$6,000
- Maximum Annual Medical Benefit, per person for 2013 \$2,000,000
Unlimited after 2013
- Out-of-pocket maximum, for an individual, each year
(not including Deductible) \$9,150
- Out-of-pocket maximum, for a family, each year
(not including Deductibles) \$18,300

Comprehensive Medical Benefit includes:

- Chiropractic Care, limit 20 sessions per year
- Diagnostic Laboratory or Pathology Test and X-Ray
- Hospital Expenses, including inpatient care, room and board, and outpatient care such as emergency room services

- Hospice Care - Daily maximum \$150
 - Bereavement counseling, per session \$25
- Medical Care, including, but not limited to, Physicians' visits, ambulance service, rental of Durable Medical Equipment, visiting nurses
- Mental or Nervous Disorder Expenses
- Organ or Tissue Transplant
- Outpatient Substance Abuse Treatment Expenses subject to Comprehensive Medical Deductible, then 50% of Usual and Customary charges (the Plan only covers 50% of such outpatient expenses even after the Out-of-Pocket Maximum is reached)
- Surgical Expenses
- Second Surgical Opinion 100% of Usual and Customary charges

Prescription Drug Benefit:

60% coverage for preferred drugs and 50% coverage for nonpreferred drugs is provided through mail order and retail pharmacies. Brand coverage is limited to generic cost when generic is available. Maintenance drugs purchased at retail are subject to reimbursement limitation. Comprehensive Medical Out-of-Pocket maximum benefit does not apply to prescription drugs but a separate annual Out-of-Pocket maximum applies to prescription drugs in the amount of \$500

III. Comprehensive Medical Coverage - How It Works

Your medical coverage is divided into Comprehensive Medical, Dental, Vision and Substance Abuse Treatment Benefits. Part IV contains a detailed description of your Comprehensive Medical Benefits and what each section covers.

Comprehensive Medical coverage includes a wide range of covered medical expenses for you and your eligible dependents. The following rules apply to Comprehensive Medical expenses.

Plan Requirements

Preferred Provider Organizations (PPO)

The Plan has contracted with various Preferred Provider Organizations, known as "PPOs", in areas where participants reside. In general, you must use PPO providers in order for the Plan to pay benefits at the "In-Network" level shown on the Summary of Benefits and Deductibles. Information regarding Physicians and Hospitals participating in your PPO is available by contacting the PPO in your area.

In addition, the following care will be treated as "In-Network":

1. Emergency care -- acute care for an illness or injury which requires immediate treatment, or which the participant reasonably believes is life threatening, or where the participant has no control over where he or she is taken for treatment;
2. Services provided by a non-PPO provider such as a lab, anesthesiologist or radiologist in a PPO Hospital when a PPO Physician is treating the individual;
3. Chiropractic treatment if chiropractors are not included in the applicable PPO Network; and
4. Care provided by a psychologist or a psychiatric social worker if these providers are not included in the applicable PPO network.
5. Services of a provider which leaves the PPO network during a continuous course of treatment of a participant for an illness or condition if, as the result of the provider leaving the network, the participant would be required to change Physicians during the course of a specific treatment. For these purposes, a continuous course of treatment means a limited and specific plan or program of treatment to address a specific illness or condition such as pregnancy or a course of chemotherapy.
6. If you live in an area covered by a PPO but there is not an appropriate PPO provider within 30 miles of where you live, your benefits will be paid at the In-Network level of benefits.

7. If a provider is treated as In-Network because of one of the above exceptions, an on-going course of treatment by that provider will also be considered In-Network.

Preventive Services

As required by federal law, Preventive Services (see Definitions, page 60) are covered by this Plan without the application of the Deductible and at 100% coverage. This level of coverage is available only to services provided by or obtained In-Network. Services provided by an Out-of-Network provider are subject to the Out-of-Network deductible and co-insurance without regard to whether the service would otherwise be considered a Preventive Service.

Regarding the coverage for the Office Visits associated with Preventive Services,

- (1) if a Preventive Service is billed separately (or is tracked as individual encounter data separately) from an office visit, then this Plan will impose cost-sharing requirements with respect to the office visit,
- (2) if a Preventive Service is not billed separately (or is not tracked as individual encounter data separately) from an office visit, and the primary purpose of the office visit is the delivery of the preventive an item or service, then this plan will not impose cost-sharing requirements with respect to the office visit and,
- (3) if a Preventive Service is not billed separately (or is not tracked as individual encounter data separately) from an office visit, and the primary purpose of the office visit is not the delivery of the preventive an item or service, then this plan will impose cost-sharing requirements with respect to the office visit.

Example:

Facts. An individual covered by this Plan visits an in-network health care provider to discuss recurring abdominal pain. During the visit, the individual has a blood pressure screening, which has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual. The provider bills the Plan for an office visit.

Conclusion. In this Example, the blood pressure screening is provided as part of an office visit for which the primary purpose was not to deliver items or services. Therefore, the Plan will impose a cost-sharing requirement for the office visit charge.

The list below shows the Preventive Services subject to this no Deductible/100% In-Network coverage as of January 1, 2011.

Covered Preventive Services for Adults

- Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
- Alcohol Misuse screening and counseling
- Aspirin use for men and women of certain ages
- Blood Pressure screening for all adults

- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal Cancer screening for adults over 50
- Depression screening for adults
- Type 2 Diabetes screening for adults with high blood pressure
- Diet counseling for adults at higher risk for chronic disease
- HIV screening for all adults at higher risk
- Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
 - Hepatitis A
 - Hepatitis B
 - Herpes Zoster
 - Human Papillomavirus
 - Influenza
 - Measles, Mumps, Rubella
 - Meningococcal
 - Pneumococcal
 - Tetanus, Diphtheria, Pertussis
 - Varicella
- Obesity screening and counseling for all adults
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
- Tobacco Use screening for all adults and cessation interventions for tobacco users
- Syphilis screening for all adults at higher risk

Covered Preventive Services for Women, Including Pregnant Women

- Anemia screening on a routine basis for pregnant women
- Bacteriuria urinary tract or other infection screening for pregnant women
- BRCA counseling about genetic testing for women at higher risk
- Breast Cancer Mammography screenings every 1 to 2 years for women over 40
- Breast Cancer Chemoprevention counseling for women at higher risk
- Breast Feeding interventions to support and promote breast feeding
- Cervical Cancer screening for sexually active women
- Chlamydia Infection screening for younger women and other women at higher risk
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
- Domestic and interpersonal violence screening and counseling for all women
- Folic Acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women
- Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years

for women with normal cytology results who are 30 or older

- Osteoporosis screening for women over age 60 depending on risk factors
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users
- Sexually Transmitted Infections (STI) counseling for sexually active women
- Syphilis screening for all pregnant women or other women at increased risk
- Well-woman visits to obtain recommended preventive services

Covered Preventive Services for Children

- Alcohol and Drug Use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments for children of all ages
- Cervical Dysplasia screening for sexually active females
- Congenital Hypothyroidism screening for newborns
- Developmental screening for children under age 3, and surveillance throughout childhood
- Dyslipidemia screening for children at higher risk of lipid disorders
- Fluoride Chemoprevention supplements for children without fluoride in their water source
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns
- Height, Weight and Body Mass Index measurements for children
- Hematocrit or Hemoglobin screening for children
- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening for adolescents at higher risk
- Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
 - Diphtheria, Tetanus, Pertussis
 - Haemophilus influenzae type b
 - Hepatitis A
 - Hepatitis B
 - Human Papillomavirus
 - Inactivated Poliovirus
 - Influenza
 - Measles, Mumps, Rubella
 - Meningococcal
 - Pneumococcal
 - Rotavirus
 - Varicella
- Iron supplements for children ages 6 to 12 months at risk for anemia
- Lead screening for children at risk of exposure
- Medical History for all children throughout development
- Obesity screening and counseling

- Oral Health risk assessment for young children
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Sexually Transmitted Infection (STI) prevention counseling for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening for all children

The Deductible

In each calendar year that you or an eligible dependent has covered Comprehensive Medical expenses, you must pay the amount shown in the Schedule of Benefits as the "Deductible." It applies separately to each eligible person in each calendar year with these two exceptions:

- Deductibles for a family cannot exceed two times the individual deductible in a calendar year. The limit is satisfied after family members collectively meet the family deductible in a calendar year.
- Any expenses applied against the Deductible for the last three months of a calendar year will also count towards the Deductible for the next calendar year.

Co-insurance of Covered Expenses

After the Deductible has been met each calendar year, the Plan will pay a percentage of covered Usual and Customary charges and the patient is responsible for the remainder. This is your co-insurance (see Definitions, page 58) amount. Your co-insurance amount may vary, depending on whether you use a PPO provider ("In-Network") and based on your plan of benefits. Co-insurances are shown on the Summaries of Benefits in Part II of this booklet.

100% Payment of Covered Expenses After Out-Of-Pocket Maximum

After an individual's covered Comprehensive Medical expenses (other than expenses for prescription drugs, out-of-hospital treatment of nervous and mental disorders or substance abuse) exceed the Deductible plus a stated amount in a calendar year, most covered benefits will be paid at 100% for that person in that calendar year. This is called your Out-of-Pocket maximum expenses. The Out-of-Pocket maximum expenses apply to each person covered under the Plan and there is no family maximum limit. The maximums are shown on the Summaries of Benefits in Part II of this booklet (See Definition, Out-of-Pocket Expenses, 68). In the event some or all of your Out-of-Pocket expenses for a calendar year are reimbursed under a provision of the Plan, those reimbursed expenses no longer count toward that year's Out-of-Pocket maximum expense. A separate Out-of-Pocket maximum applies to prescription drugs.

The Out-of-Pocket maximum for a family cannot exceed two times the individual Out-of-Pocket maximum in a calendar year. The limit is satisfied after family members collectively meet the family Out-of-Pocket maximum in a calendar year.

Annual Maximum Benefit

Each eligible person has an annual maximum benefit for the Comprehensive Medical coverage. This amount will be \$ 2,000,000 in 2013. Thereafter, the NASMT Welfare Fund will not be subject to a maximum annual benefit limitation.

Exceptions

Maximums and co-insurance amounts differ depending on whether you are using an "In-Network" service provider through a PPO, and on your level of benefits. Please see the Summaries of Benefits in Part II of this booklet for details.

It is common practice for participants to authorize the Fund to pay benefits directly to a Hospital or Physician. While the Fund routinely honors such directions, it is under no obligation to do so in every case. For example, if there has been a benefit overpayment, or you otherwise owe money to the Fund, the Fund may choose to offset the overpayment against future benefits even if you have requested that benefits be paid directly to your Hospital or Physician. This is true even if the Fund has pre-certified coverage.

Pre-Certification of Hospital Admission

Call 1-866-343-3709 as soon as you or your dependent are planning an admission, preferably at least 7 days prior to the anticipated admission date or within 48 hours after an emergency admission. This applies to medical, surgical, psychiatric and substance abuse inpatient hospitalization.

This call may come from you, a family member, friend, admitting Physician, or Hospital and is used to identify the member, the patient, and the Physician. You speak with a Medical Review Specialist, a specially trained Registered Nurse, who asks for the patient's name, age and the Physician's name and phone number. The Specialist then contacts your Physician and continues to monitor your case until discharge. The Medical Review Specialist discusses with your Physician the admitting diagnosis, the procedure(s) to be performed during the hospitalization, the treatment plan and the approximate number of days of confinement required.

Notification of your certified admission is provided to your physician, the hospital and the Fund Office 24 hours after certification.

Continued Stay Review

During your hospitalization, the medical review staff monitors your hospital stay to make sure that you were admitted as planned and, provided no complications arise, that you are discharged on the scheduled day.

Catastrophic Medical Case Management

Some seriously ill patients have complex medical situations that cannot be effectively reviewed in a phone conversation. Such situations might include premature infants, cancer patients, head injuries, spinal cord injuries, AIDS victims, or adolescent psychiatric cases. Such cases are automatically identified for special attention through the Hospital Pre-Certification process.

After a case is identified and discussions are held with the attending physician, a Case Manager (a specially trained Registered Nurse) within the patient's geographic area, contacts the Fund

Office and the patient/family within twenty-four hours to arrange an initial meeting. During this meeting, the Case Manager discusses any questions that the patient/family might have and helps you and your physician explore all possible alternatives to your current level of care. The Case Manager is familiar with local resources and custom, and is tied into a sophisticated national network of leading medical providers. In this way, a collective body of specialized medical expertise can be focused on your case to enhance your recovery/rehabilitation. Once you and your physician select the treatment plan, the Case Manager can help coordinate and implement your decision.

If you have been discharged from an inpatient psychiatric program, experienced mental health personnel review your case. Contacts are made with your Physician to discuss the appropriateness of treatment, certify specific additional visits and determine a reasonable time at which measurable progress should be made.

Covered Services

Comprehensive Medical coverage includes expenses incurred for hospital, surgical, medical care, home care, diagnostic/pathology/x-ray tests, organ and tissue transplants, mental and nervous disorder treatment, substance abuse treatment, hospice care, rehabilitation care in a Convalescent Facility (See Definitions, page 58), well-child care, chiropractic care, prescription drugs, and second surgical opinions.

Covered services are discussed in more detail in Part IV of this booklet, entitled "Benefits." It is important, however, that you become familiar with the limitations and general exclusions described in the following paragraphs because they affect the scope of your coverage under this Plan.

Limitations and Exclusions

Covered Services are subject to the following limitations and general exclusions. Please read this section carefully. Becoming familiar with the limits imposed will help you understand what services are covered and the level of your coverage.

Comprehensive Medical Benefit Limitations

In general, the National Automatic Sprinkler Metal Trades Welfare Fund covers expenses for non-work related illness or injuries. Therefore, Comprehensive Medical Coverage does not include:

1. routine physical examinations except once per year;
2. eye refraction except following accidental injury, eye-glasses, contact lenses, lens implants or fittings except as necessary in connection with cataract surgery;
3. charges for furniture installation, set-up, or maintenance or modifications to home or car;
4. educational training for natural childbirth;
5. charges for delivery by a Physician for the same delivery services rendered by a nurse-midwife unless the Physician's services are rendered as a result of complication of pregnancy. Complication of pregnancy means any pregnancy other than one terminating by normal delivery or miscarriage;
6. transsexual surgery and services relating to transgender cases;
7. in vitro fertilization, artificial insemination;
8. services to reverse voluntary, surgically induced infertility;
9. services and supplies not prescribed;
10. therapeutic devices, including but not limited to hypodermic needles, syringes, support garments, or other nonmedical substances purchased for self-use, except paraphernalia necessary for the administration of insulin;
11. replacement or repair of a prosthetic appliance unless outgrown;
12. orthotics: orthopedic shoes (except when joined to braces) or supportive devices for the feet, including, but not limited to, arch supports and heel lifts;
13. routine care of feet, including callus or corn paring; trimming of toenail; or treatment of chronic conditions of the foot;

14. radial keratotomy; LASIK and other refractive surgery;
15. acupuncture;
16. organ transplants except as specifically provided by the plan;
17. therapy for marriage-related problems;
18. physical, occupational, myofunctional therapy, or pulmonary rehabilitation except following illness or injury;
19. non-medical services associated with learning disabilities, mental retardation, developmental delay, attention deficit disorder, autistic disease of childhood, behavioral problem, special education;
20. hypnotism, stress management, or goal-oriented behavior modification therapy;
21. cosmetic, plastic, or reconstructive surgery except to repair or alleviate damage resulting from or caused by injury, congenital defect or disfigurement related to disease;
22. construction, services, purchase or rental of supplies, appliances, or equipment for personal hygiene, beautification, comfort or convenience;
23. travel or lodging;
24. transportation of a family member or of medical personnel, equipment or supplies;
25. the pregnancy, childbirth, or miscarriage of a dependent child unless treatment is necessary to save the life of the dependent child or the Trustees determine that the pregnancy is the result of a violent or criminal act against the dependent child;
26. services not related to specific diseases.
27. dental services except as required for treatment of an injury to sound natural teeth

In addition to Comprehensive Medical Benefit Limitations, the following limitations also apply:

Second Surgical Opinion Limitations

The Second Surgical Opinion Benefit does not include a consultation:

1. with a Physician who is not certified as a specialist in the medical field of the proposed surgery;
2. with a Physician or associate of the Physician who performs the surgery or has a financial interest in the outcome of the recommendation:

3. in connection with proposed surgery for which a surgical benefit would not be payable under the Plan;
4. unless the patient is examined in person by the Physician rendering the second or third medical opinion;
5. obtained after surgery is performed; or
6. in excess of two consultations in connection with the proposed surgery.

Hospital Expenses Limitations

Hospital Expenses do not include:

1. Hospitalization for dental care unless certified by your Physician as necessary to protect your life or health;
2. Hospitalization primarily for diagnostic study directed toward a definite illness or injury where treatment consists of physical therapy, hydrotherapy or occupational therapy unless the services can be provided only on an inpatient basis and the patient's physical condition requires hospitalization.

Durable Medical Equipment Limitations

Covered Expenses include Durable Medical Equipment when it is prescribed by a physician who documents the necessity of the item, it is necessary for the treatment of a disease or injury to improve body function lost as the result of a disease, injury or congenital abnormality or is Medically Necessary to enable the patient to perform essential activities of daily living. Examples of these activities include eating, toileting, bathing, walking, transferring from bed to chair and bed to wheelchair or walker. However, it does not include equipment to enable someone to drive a vehicle, or equipment solely for the convenience of the patient's caretaker.

Expenses for Durable Medical Equipment are not covered unless the equipment

1. is of strong construction for repeated use;
2. is appropriate for home use and is safe and effective without medical supervision;
3. is primarily and customarily used to serve a medical purpose and is not normally of use to persons who do not have a disease or injury;
4. is not aesthetic in nature;
5. is less expensive than alternative equipment;

6. is not used to enhance the home or environment, to change temperature or humidity or air quality;
7. is not for exercise or training;
8. is not for the treatment of temporomandibular joint (TMJ) syndrome.

Diagnostic Laboratory, Pathology, and X-Ray Expenses Limitations

Diagnostic Laboratory and Pathology Test and X-Ray Examination expenses do not include:

1. X-ray examinations without film;
2. dental X-rays unless required due to injury to natural teeth (Dental X-rays may be covered under Dental Care); and
3. camp, school and employment physical; pre-marital blood tests and similar tests.

Covered Organ or Tissue Transplants Limitations

Covered Organ or Tissue Transplant coverage does not cover:

1. transplants other than those listed as a Covered Transplant Procedure;
2. animal organ or tissue;
3. charges for procedures not generally accepted by the medical profession as safe, effective, and appropriate treatment of the patient's medical condition; and
4. charges for lodging or for the preservation, storage or transplantation of a tissue or organ of a donor.

Hospice Care Limitations

Hospice Care does not include the following:

1. care in a Hospice that is not Medicare-certified;
2. care unless life expectancy is six months or less;
3. bereavement counseling exceeding a maximum of 12 sessions within six months after the patient's death;
4. services provided by a volunteer, pastoral counselor or someone who does not normally charge for his services, a person who ordinarily resides in your home, or a member of your family;

5. services that could have been provided by a properly trained person of the eligible person's household without endangering his life or seriously impairing his condition;
6. custodial, domestic, or housekeeping services;
7. services of a masseur, physical culturist, companion or sitter, or physical education instructor.

Rehabilitation Care Limitations

Rehabilitation Care does not include Custodial Care (See Definitions, page 58).

Chiropractic Care Limitations

Chiropractic Care does not include:

1. a follow-up visit unless a chiropractic manipulation is performed during the visit;
2. charges for more than 20 visits per calendar year;
3. charges for more than two additional modalities per day in addition to the chiropractic manipulation; and
4. expenses for laboratory tests.

Prescription Drugs Limitations

If your physician prescribes a drug for which a generic equivalent exists, the NAS Metal Trades Welfare Fund will provide reimbursement only up to the cost of the generic equivalent, even if your doctor says the prescription must be dispensed as written.

No Prescription Drug benefits are payable for:

1. a non-legend, patent or proprietary drug, medicine or medication not requiring a prescription, except insulin, unless the drug, medicine, or medication is a compounding of two or more drugs, medicines, or medications, which compounding, by law, must be prescribed;
2. separate charges for medication, legend or non-legend, that is consumed or administered, in whole or in part, at the place where it is dispensed;
3. drugs or devices for birth control;

4. nonprescription drugs and vitamins, minerals, laetrile, enzymes, diet foods, or dietary supplements whether prescribed or not except such vitamins and minerals that meet the definition of Preventive Services (see Definitions, page 60).
5. because there are effective over-the-counter alternatives for proton-pump inhibitors (“PPIs”) and for non-sedating antihistamines, prescription drug coverage does not include coverage for PPIs or for non-sedating antihistamines whether prescribed or not except for individuals with one (or more) of the following medical conditions in which case PPI coverage is available:
 - Hypersecretory conditions such as Zollinger-Ellison Syndrome, mastocytosis, and multiple endocrine adenomas
 - Barrett’s Esophagus
 - Esophageal peptic stricture
 - Erosive esophagitis
 - Esophageal cancer

Additionally, coverage of PPIs will be provided for individuals for whom it is medically established that the individual needs a PPI that is not available over-the-counter.

Mail-Order Maintenance Drug Benefit Limitations

If you purchase maintenance drugs from a source other than Express Scripts, reimbursement will be limited to the cost of that through Express Scripts.

General Exclusions

The Plan does not pay "medical" benefit expenses unless the charge is for services or supplies covered by the Plan. In addition, the Plan does not pay for charges in connection with the following:

1. medical services or supplies, including prescription drugs, considered educational, investigational, or experimental. A drug, device or medical treatment or procedure is considered experimental or investigational if:
 - a. it is a drug or device that cannot be lawfully marketed without approval of the U. S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
 - b. if reliable evidence shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, II, or III clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
 - c. if Reliable Evidence shows that the consensus of opinion among experts regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

For this purpose, Reliable Evidence means only published reports and articles in the authoritative medical and scientific literature: the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

2. medical services or supplies available without cost or not legally required to be paid in absence of the Plan;
3. medical services or supplies furnished in or by a federal, state, or local government agency or program or in or by a Hospital or institution unless required by law;
4. medical services or supplies, including prescription drugs, furnished in or by a nursing home, sanatorium, rest home, convalescent home, extended care facility or similar establishment unless it is a Convalescent Facility;
5. private duty nursing care, unless ordered by the Physician as Medically Necessary (See Definitions, page 59);
6. Custodial Care or domiciliary care regardless of the facility where provided;
7. medical services or supplies furnished by an individual who ordinarily resides in the patient's home or is related to the patient by blood or marriage;
8. services not rendered, or in an amount more than the amount billed;
9. charges for services or supplies in excess of Usual and Customary (See Definitions, page 66);
10. expenses that are not Medically Necessary (See Definitions, page 59);
11. services rendered by an individual who does not meet the definition of Physician (see page 60);
12. services rendered primarily for training or educational purposes; and
13. food or food supplements.

The plan does not pay medical or non-medical charges in connection with the following:

1. services or supplies for an injury or illness that arises out of the course of employment whether or not compensable under workers' compensation, occupational disease, or similar laws. Under specific circumstances, the Fund may pay such benefits subject to the right of reimbursement. See pages 65 through 68.

2. an injury or illness resulting from military service or caused by an act of war;
3. claims not submitted within two years of the time the service was rendered or the event occurred;
4. charges for failure to keep a scheduled appointment or for the completion of any form; or
5. services or supplies to the extent covered by state or federal no-fault insurance or expenses which are covered under third-party liability insurance coverage, such as homeowners' or automobile insurance.

IV. Benefits

Comprehensive Medical Benefits

Comprehensive Medical coverage includes the following categories of health benefits. Remember, Comprehensive Medical coverage is subject to Deductibles, copayment rules, and the limitations and exclusions described in Part III of this booklet.

Hospital Expenses

The Plan pays Hospital Expenses, including:

1. room and board for semi-private room;
2. operating, delivery, recovery and treatment room and equipment fees;
3. diagnostic laboratory and pathology tests, including electrocardiogram and electroencephalograms;
4. X-ray examinations;
5. radiotherapy including use of X-ray, radon, radium, cobalt, and other radioactive substances;
6. services or supplies furnished by a Hospital for treatment in the outpatient department, emergency room or ambulatory surgical facility;
7. pre-surgical tests;
8. bandages, surgical dressings, casts, splints, trusses, braces, and crutches;
9. prescription drugs taken or administered during hospitalization;
10. anesthesia and its administration;
11. oxygen and its administration;
12. whole blood, blood plasma, plasma extenders, and blood transfusions;
13. routine nursery care of a newborn child of an eligible employee;
14. in-patient treatment of a mental or nervous disorder;
15. confinement for medical complications of alcoholism or drug abuse, including cirrhosis, delirium tremens, hepatitis; and

16. general nursing care services of a Registered Nurse (RN) or a Licensed Practical Nurse (LPN).

Surgical Expenses

The Plan pays surgical expenses, including:

1. an incision, excision, or electrocauterization of any organ or part of the body;
2. treatment of a fracture;
3. cosmetic, plastic or reconstructive surgery to repair injury, or disfigurement related to disease, or for repair of congenital defects provided the individual was eligible for benefits at birth;
4. reduction of a dislocation;
5. an endoscopic procedure;
6. suturing of wounds;
7. X-ray or radium therapy or laser therapy if used in lieu of a cutting operation;
8. injection treatment of hernias, hemorrhoids, or varicose veins;
9. anesthesia services;
10. services of a dentist or Physician for repair of injury to sound natural teeth; and
11. assistant surgeon fees not to exceed 20% of the surgical expense.

Medical Care Expenses

The following services and supplies are payable if furnished on an inpatient basis or as an outpatient in an emergency room of a Hospital, in a Physician's office or an Outpatient Facility (See Definitions, page 66):

1. Physician visits; (no benefit is payable for a visit in the Hospital in connection with a surgical procedure or post-operative care unless the visit is by a Physician other than the surgeon performing the operation);
2. services of a nurse-midwife (for eligible employees or the spouse of an eligible employee) up to an amount that does not exceed the amount that would be payable if the services were performed by a Physician;

3. rental of a wheelchair, hospital-type bed, mechanical devise for treatment of respiratory paralysis or other durable medical equipment;
4. orthopedic appliance implants;
5. services by a licensed practitioner for physical therapy, hydrotherapy, or occupational therapy;
6. speech therapy through the use of appropriate programs for treatment of developmental speech dysfunction resulting from injury or illness;
7. kidney dialysis when performed in a Medicare-approved facility;
8. ambulance service for emergency transportation to or from the nearest Hospital equipped to provide the required medical care;
9. orthopedic braces and appliances;
10. prosthetic devices or implants;
11. immunizations within standard medical practice;
12. oxygen;
13. visiting nurses; and
14. services of a dentist or Physician required as a result of injury to sound natural teeth.

Medical Care in the Home

The Plan covers the following medical services or supplies in the home:

1. hemodialysis (if less expensive than dialysis in a Medicare-approved facility), including the reasonable cost of an artificial kidney machine, Medically Necessary supplies, services and training, home-testing for dialysis and rental of durable medical equipment. All charges are reduced by any expenses covered by Medicare;
2. charges for IV therapy and training of the patient or others to administer the medication; and
3. Physician's visits.

Diagnostic Laboratory and Pathology Test and X-Ray Examination Expenses

The Plan covers expenses incurred for laboratory and pathology tests and for X-ray examinations performed for diagnostic testing.

Organ or Tissue Transplants

Under certain circumstances, the Plan pays for Covered Expenses for Covered Organ or Tissue Transplant Services for you or your eligible dependent. Covered Expenses are subject to the Comprehensive Medical Deductible and Co-insurance rules applicable to all Comprehensive Medical Care.

Covered Organ or Tissue Transplant Services consist of the following:

1. organ and tissue procurement consisting of the removal from a cadaver, preservation, storage, and transporting of the organ or tissue, if you or your dependent is the recipient;
2. reasonable expenses of an uninsured live donor as a recipient's Covered Expense, if you or your eligible dependent is the recipient;
3. reasonable charges for transportation to the nearest transplant facility;
4. if you or your eligible dependent is a donor for a Covered Transplant Procedure, reasonable expenses for donor testing and charges for removing the organ or tissue, and other reasonable expenses in the same manner as for treatment of illness; and
5. other services that would be covered under the Comprehensive Medical Benefit in the same manner as any other treatment or injury.

The Plan pays for the following Covered Transplant Procedures of human-to-human organ or tissue:

1. bone marrow (conventional or autologous);
2. heart;
3. liver;
4. kidney; and
5. cornea.

Mental or Nervous Disorder Treatment

The plan covers treatment for mental or nervous disorders.

Substance Abuse Treatment

The Plan covers individual or group therapy on an inpatient basis, and inpatient or outpatient treatment by a psychiatrist, licensed clinical psychologist or similar professional who is in private practice and licensed to practice substance abuse treatment.

Hospice Care

Hospice Care consists of expenses for the following medical care if you or your dependent are terminally ill:

1. home visits by nurses and other health care professionals;
2. management of pain;
3. medical treatments as prescribed;
4. instruction and supervision for family members in the care of the patient;
5. help in obtaining medical equipment, supplies or medication;
6. psychological counseling and emotional support to the patient and family; and
7. inpatient confinement in a Hospice facility.

Rehabilitation Care in Convalescent Facility

Rehabilitation Care means services and supplies that are provided within generally accepted medical standards to establish a program of medical treatment which can reasonably be expected to contribute substantially to the improvement of the individual's medical condition and is not merely for maintenance or stabilization of such individual's medical condition.

Rehabilitation Care includes expenses for room and board, meals, occupational, speech and physical therapy, and general services and supplies essential to daily medical care, if these services or supplies would be payable as Hospital Expenses and if the confinement is Medically Necessary and constitutes appropriate alternative care as determined by the Plan's medical review process.

Well Care

The Plan covers expenses related to a routine physical examination (including routine OB/GYN exams) by a Physician. This benefit is limited to one examination per year for each participant and each covered dependent unless such care meets the definition of Preventive Services (See Definitions on page 65). In addition, routine immunizations, including diphtheria/tetanus/pertussis (DTP), measles/mumps/rubella (MMR), poliomyelitis, and influenza are covered.

Chiropractic Care

Chiropractic Care includes expenses for the initial office visit (including patient history, examination, and diagnostic X-rays) and follow-up visits for manipulation for treatment of spinal maladjustments or subluxation.

Prescription Drug Coverage

Prescription Drugs include legend drugs, injectable insulin, or other state-controlled drugs that, by law, must be prescribed by a Physician and dispensed by a licensed pharmacist.

To ensure the appropriate use of prescription drug coverage, the Trustees may inquire into the facts and circumstances of the purchase of any prescription drug, including prescription and refill details.

There are two parts to the Pharmaceutical services the Plan provides through Express Scripts:

1. The Retail Pharmacy - The prescription card will allow you and your eligible dependents to purchase any non-maintenance prescriptions covered by the Plan at discounted prices. You will pay only your portion of the cost depending on the Level of Benefits that applies to you. You will also be allowed to purchase any first-time maintenance prescription drugs, up to a 30-day supply two times at the Retail Pharmacy. Reimbursement for additional refills of maintenance medications at the Retail Pharmacy is available, but you must purchase paying the full price for the prescription and then submit the receipt to the Plan for reimbursement. In such circumstances, the amount of the reimbursement will be limited to the amount the prescription would have cost the Plan had you used the Mail-Order pharmacy.
2. The Mail Order Service - The Plan provides an opportunity for you to purchase long-term "maintenance" prescription drugs, at significantly reduced costs, through the mail from Express Scripts. Mail order is a convenient way to save money on the purchase of your prescription maintenance medications. (A few examples of conditions treated with maintenance drugs are high blood pressure, ulcers, arthritis, heart or thyroid conditions, emphysema, and diabetes.)

You will receive your order within 10-14 days after Express Scripts receives your order. Your medication will be delivered to your home via UPS or first class U.S. mail. Your participation in this program is completely voluntary. When you use this method of purchasing your maintenance drug prescriptions, you may obtain up to a 90-day supply. You are responsible for the usual 40% (or, as applicable, 50% or other) co-insurance on the discounted prescription drug cost.

Unless your Physician specifically requires a brand-name drug, your prescription will be filled with the generic equivalent, when available and permissible by law. Generic drugs are subject to the same FDA (Food and Drug Administration) regulations and require the same high standards for purity, strength, safety and effectiveness as brand-name medications.

The Plan does not cover charges that exceed the Express Scripts price for maintenance drugs.

Substance Abuse Treatment Benefit

Substance Abuse Treatment includes expenses incurred for medical care if you (or your dependent) are confined in a Treatment Facility for treatment and rehabilitation related to alcoholism or chemical dependency.

The Plan pays charges related to Treatment Facility confinement that are charged by the Facility or are generally charged by a Facility. Examples include:

1. room and board;
2. psychological testing;
3. prescription drugs;
4. detoxification;
5. family counseling;
6. Laboratory tests;
7. drug screening; and
8. individual or group therapy.

If you (or your dependent) are confined as an inpatient in a Hospital solely for the treatment of a medical complication of alcoholism or drug abuse (such as cirrhosis of the liver, delirium tremens, or hepatitis), the Plan covers such confinement to the same extent as for any other disease.

Treatment Facility

To qualify as a Treatment Facility, an institution or unit of a Hospital must meet all applicable licensing standards of the jurisdiction in which it is located and must generally meet the following criteria:

1. primarily engage on a full-time basis in providing, for compensation from its patients, a program for diagnosis, evaluation, and effective treatment of alcoholism or drug abuse, whichever condition is being treated;
2. provide all medical detoxification services necessary as an adjunct to its effective treatment programs continuously on a 24-hour basis;

3. provide all normal infirmary-level medical services required for the treatment of any disease or injury manifested during the treatment period; whether or not related to the alcoholism or drug abuse, continuously on a 24-hour basis; provide or have an agreement with a Hospital in the area to provide, any other medical services that may be required during the treatment period;
4. function under the supervision of a staff of Physicians on a continuous 24-hour basis and provide skilled nursing services by licensed nursing personnel under the direction of a full-time registered graduate nurse; and
5. prepare and maintain a written individual plan of treatment for each patient based on a diagnostic assessment of the patient's medical, psychological and social needs with documentation that the plan is under the supervision of a Physician.

V. Definitions

The following terms have special meanings when used in this Summary Plan Description.

Collective Bargaining Agreement

means the labor agreement in force and effect between a sprinkler fitter Local Union and the National Fire Sprinkler Association or an employer together with any modifications, supplements or amendments.

Co-insurance

means the percentage of covered Usual and Customary charges which you are responsible to pay after the Deductible has been met each calendar year. For example, if the Plan will pay 70% of the Usual and Customary charges for Covered Expenses under the Comprehensive Medical Coverage, you are responsible for 30% of the Usual and Customary charges for such Covered Expenses. You are also responsible for payment of any balance that exceeds the Usual and Customary charge.

Convalescent Facility

means an institution that is licensed to keep patients regularly overnight. The facility must provide supervision by a legally qualified Physician or a registered professional nurse, 24-hour skilled nursing care by licensed nursing personnel under the direction of a full-time registered professional nurse, and training in self-care for the essential activities of daily living. The institution must also maintain a complete medical record on each patient and have a utilization review plan for all of its patients. An institution is not a Convalescent Facility if it is used principally for the care of mental retardation or any other form of mental disorder. Institutions such as clinics, or places for rest, educational care, care of the aged, Custodial Care, care of drug addicts or alcoholics do not qualify as Convalescent Facilities. To qualify for coverage, confinement in a Convalescent Facility must occur within 14 days after a minimum three-day Hospital confinement for the same illness.

Covered Expense

means a charge to the extent it is within the Usual and Customary amount that is allowable under the Plan for a service or supply that is Medically Necessary for diagnosis, treatment, mitigation or cure of an illness or injury to a structure or function of the mind or body. No amount in excess of the actual charge for a service or supply will be considered a Covered Expense.

Custodial Care

means services and supplies, including room and board and other institutional services, which are provided whether or not you are Disabled, primarily to assist you in the activities of daily living. Such services and supplies are Custodial Care without regard to the practitioner or

provider by whom or by which they are prescribed, recommended or performed. Room and board and skilled nursing services, when provided in a Hospital or other institution for which coverage is specifically provided, are not Custodial Care when such services must be combined with other necessary therapeutic services and supplies in accordance with generally accepted medical standards to establish a program of medical treatment which can reasonably be expected to contribute substantially to the improvement of the individual's medical condition and is not merely for the maintenance or stabilization of such individual's medical condition.

Deductible

means the total Out-of-Pocket Covered Expenses that you must pay each year before a benefit is payable from the Plan. The Deductible is taken from the first expenses you incur during a calendar year. Any expenses incurred during the last three months of a calendar year and applied against the Deductible will also be applied against the Deductible for the next calendar year.

Disability and Disabled

mean the inability to perform the duties of your occupation because of a medically determinable physical or mental impairment, as certified by your Physician, and the inability to receive substantial compensation for any employment. For a dependent, Disability means the inability to perform, due to a medically determinable physical or mental impairment, the functions and activities of a person of like age and sex who is in good health.

Hospital

means an institution that is accredited as a Hospital by the Joint Commission on Accreditation of Health Care Organizations or any similar Hospital in a foreign country. A licensed facility that is set up, equipped, and operated under the direction of a Physician solely as a birthing center for prenatal care, delivery, and immediate postpartum care is a "Hospital." Hospital does not include rest or nursing homes, convalescent homes or institutions, sanatoriums or similar institutions which primarily operate training schools for patients or primarily provide Custodial or institutional care. To be considered a Hospital for purposes of this Plan, a Hospital must: regularly keep patients overnight; have full diagnostic, surgical and therapeutic facilities under the supervision of a staff of legally qualified Physicians; and regularly provide 24-hour nursing service by registered graduate nurses.

Medically Necessary

means services or supplies that are: furnished or prescribed by a Physician or other licensed provider to identify or treat a diagnosed or reasonably suspected illness or injury; consistent with the diagnosis and treatment of the patient's condition; in accordance with standards of good medical practice; is generally accepted by the medical profession as safe, effective and appropriate treatment of the patient's medical condition; is required for reasons other than the convenience of the patient, Physician, or other licensed provider; and the most appropriate level of service or supply that can be provided safely for the patient. When the term "Medically Necessary" is used to describe inpatient care in a Hospital, it means that your medical symptoms

and condition are such that the service or supply cannot be provided safely on an outpatient basis. The fact that services or supplies are furnished or prescribed by a Physician or other licensed provider does not necessarily mean that the services and supplies are "Medically Necessary."

Out-of-Pocket Expenses

means an individual's co-insurance portion of the medical expenses not paid by the Plan in that calendar year (not including expenses for the outpatient treatment of mental and nervous disorders). For example, an individual submits claims for medical services in the amount of \$1,300. That member is eligible under a plan that has a \$300 individual Deductible and 80% coverage, so the plan pays 80% of \$1,000 (\$1,300 less the \$300 Deductible) or \$800. The individual's Out-of-Pocket Expense is \$200 even though the individual is also responsible for the \$300 Deductible. Out-of-Pocket Expenses apply to each person covered under the Plan and there is no family maximum limit.

Outpatient Facility

means a clinic or other establishment that provides surgery, diagnosis, and treatment on an outpatient basis. The facility must have an attending medical staff consisting of at least one Physician and anesthesiologist (or a nurse anesthetist under the supervision of a Physician). Outpatient Facilities include alternative care facilities such as Emergicenters or 24-hour clinics. The following are not Outpatient Facilities: Convalescent homes, nursing homes, homes for the needy, homes for nursing and domiciliary care, infirmaries or orphanages, sanatoriums, maternity homes for prenatal or postnatal care, mental health facilities, or other homes or institutions primarily providing Custodial Care. Other facilities, not otherwise covered by the Plan, may be approved in advance by the Fund if they fall within standard medical practice and treatment is recommended by a Physician.

Physician

means a person who is licensed to practice medicine or to perform surgery in the state in which they practice, who is practicing within the scope of his or her license and who is providing a service covered by the Plan. Physician includes a doctor of medicine, osteopathy, dental surgery, or podiatry. Physician charges also include the services of a qualified professional chiropractor, physical therapist, psychologist, occupational therapist, optometrist, nurse-midwife, nurse anesthetist and physician's assistant.

Preventive Services

means evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved; immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided

for in comprehensive guidelines supported by the Health Resources and Services Administration; and with respect to women, to the extent not described above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration, when services are obtained through a preferred provider (or pharmacy benefit manager, as appropriate). Any change to a recommendation or guideline that occurs after September 23, 2009 will be covered as a preventive service as of the first day of the first plan year beginning on or after the date that is one year after the new recommendation or guideline went into effect.

Spouse

means a person to whom a covered employee or retiree is considered married under applicable law, provided that, notwithstanding applicable law, an individual of the same sex as the covered employee or retiree shall not be treated as a covered employee's or retiree's spouse for purposes of this plan.

Total Disability and Totally Disabled

means your complete inability to engage in substantial, gainful activity because of a medically determinable physical or mental impairment that is expected to last permanently or indefinitely. Proof of your eligibility for a Social Security Disability Award is proof of Total Disability. For a dependent, Total Disability means the complete inability to perform the functions and activities of a person of like sex and age who is in good health, due to a medically determinable physical or mental impairment that is expected to last permanently or indefinitely.

Usual and Customary (UC)

means a level of charges that does not exceed the prevailing level generally charged by providers in the "locality" for like or comparable services or supplies. The term "locality" means a geographical area that includes a cross-section of persons or entities regularly furnishing the type of treatment, services, or supplies for which the charge is made. In determining whether charges are Usual and Customary, consideration is given to the condition being treated and to any medical complications or unusual circumstances that may require additional time, skill, or experience. Benefits are payable according to the plan's UC scale as determined and changed from time to time by the Board of Trustees. Where appropriate, the UC charge is based upon the scale promulgated by the Health Insurance Association of America also known as Ingenix; however, other industry sources are used if the Ingenix scale is not available. In any event, Covered Expenses under this plan must not exceed the actual amount charged for a service or supply, up to the Usual and Customary level, except where medical service is rendered on an emergency basis.

VI. Coordination of Benefits

What "Coordination" Means

Your Medical, Dental, Vision and Weekly Disability Income Benefits are "coordinated" with any benefits payable to you or to your covered dependents for the same expenses from other insurance plans.

Coordination means that benefits from the Plan described in this booklet and from other benefit plans can total, but not exceed, 100% of allowable expenses for each covered person in each calendar year. It is intended to permit full payment of actual Allowable Expenses without unnecessary duplication of benefits.

"Allowable Expenses" are any necessary, Usual and Customary charges for Medical, Dental, and Vision Benefits and services covered in full or in part under this Plan and any other plan to which the person making the claim belongs. For Weekly Disability Income Benefits, "Allowable Expenses" are two-thirds of your average weekly earnings during the 12-month period prior to your Disability.

Expenses not covered by any plan to which a person belongs are not Allowable Expenses – for example, charges for personal comfort items such as television rental in the Hospital.

"Other insurance plans" include group plans (insured or self-insured) such as benefits available from your spouse's employer, and Medicare. For employees (and their dependents) who are on the unemployment extension, on any Disability or maternity extension, or who are retired, "other insurance plans" also includes any individual or private insurance policies.

How Coordination Works If Covered Under a Group Health Plan

This Plan always pays allowable expenses after a plan that does not have a coordination of benefits provision. In addition, the following rules apply:

- A plan covering you as an employee pays benefits before a plan covering you as a dependent or retiree.
- For someone who is covered as a dependent under the plans of both parents, the plan of the parent whose birthday falls earlier in the year will pay before the plan of the other parent. This "Birthday Rule" applies only if both plans contain the same rule. If the other plan pays benefits under the gender rule, then the plan covering the male head of household pays first.
- If a husband and wife are both eligible employees under this Plan, they are treated as covered under two separate plans and benefits are coordinated according to these rules.

- If priority still is not established, the plan that has been in effect for the longer period of time pays benefits first.
- The following special rules apply for dependent coverage in case of legal separation or divorce:
 - If the parent with custody has not remarried, the benefit plan covering the parent with custody pays first. The plan covering the parent without custody pays second.
 - If the parent with custody has remarried, the benefit plan covering the parent with custody pays first. The stepparent's plan pays second. The plan of the parent without custody pays third.

Your Coordination of Benefits "Savings Bank"

When the Fund is able to save dollars that would have been payable on your behalf in the absence of other insurance, the Plan creates a Coordination of Benefits "Savings Bank" for you. The Savings Bank is credited with the difference between the benefit payable without other coverage and the amount actually paid by National Automatic Sprinkler Metal Trades Welfare Fund for an allowable expense. Savings for any one year are held and subsequent bills incurred in that year may be paid from that year's savings.

The following is an example of how the Fund uses this Savings Bank concept to pay a greater amount on a benefit than would otherwise be allowable.

Mrs. Smith is the dependent spouse of an eligible participant. She has insurance through her employer in addition to her coverage under the NAS Metal Trades Welfare Fund. She goes to the emergency room for an acute illness. The hospital charges \$1,000 for their services. After a \$100 Deductible, her employer's insurance will pay 90% of \$900, or \$810.

In the absence of other coverage, the NAS Metal Trades Welfare Fund would apply a \$500 Deductible (assuming Mrs. Smith has Level A benefits) and would cover 70% of the \$500 balance. Although the Fund has a benefit payable of \$350, only \$190 remains to be paid of the hospital's \$1,000 charge. The Fund adjusts its benefit payment by \$160.00 and pays the hospital \$190.

On this claim, the NAS Metal Trades Welfare Fund has saved \$160.00. The hospital is paid in full and a Savings Bank is created in the amount of \$160.00 for use on any other medical claim incurred by Mrs. Smith in that calendar year.

Suppose Mrs. Smith leaves employment in that year and loses her employer-provided coverage. She goes to the Physician for her annual physical for which the Physician charges \$200. The NAS Metal Trades Welfare Fund's normal benefit payment of 70% for this service would pay \$140. However, in this example, the Plan will pay the full \$200 expense after deducting \$60 from Mrs. Smith's Savings Bank.

If the Allowable Expenses on any other claim for Mrs. Smith for that year are not fully reimbursed by the combination of other coverage and the National Automatic Sprinkler Metal Trades Welfare Fund coverage, the Fund will draw from the Savings Bank the amount necessary to reimburse any unpaid Allowable Expense.

Please bear in mind that savings are not transferable from one year to another; savings from one individual cannot be used to increase the benefit of another individual.

Medicare Coordination at Age 65 for Active Employees

At age 65 you become eligible for Medicare benefits. As long as you continue to work and have enough hours or make the required self-payments, you continue to be covered by the Fund's medical benefits as an active employee. Medical benefits provided by the Fund will be your primary coverage (and your spouse's, if he or she is also eligible for Medicare); Medicare Benefits will be secondary. You will have the benefit of two coverages. As long as you remain eligible due to hours worked or employee self-payments, you should continue to submit your claims to the Fund. After payment by the Fund, you can submit any remaining expenses to Medicare for possible payment.

Active disabled employees (as defined in Federal Regulations) also receive primary coverage from the Fund and secondary coverage from Medicare as described above.

In making your decision, the following points should be kept in mind:

- Having coverage under this Plan and Medicare obviously provides the greatest protection.
- You are responsible for enrolling for Medicare.
- Be sure to consider how long you expect to work and what will happen to your coverage when you stop working. You may not be able to enroll for Medicare exactly when coverage of this Plan stops.

Coverage for Retirees with Medicare

If you are a retired or inactive disabled employee or the dependent of a retired employee (including an employee on a disability pension) and you become eligible for Medicare, Medicare will be your primary coverage. After Medicare has covered the expense, the Fund will apply the plan provisions (deductible and co-insurance) to the balance of the bill remaining after the Medicare payment. As an example, assume a \$5,000 total claim where Medicare paid \$4,000. The remaining \$1,000 will be considered for payment under the plan's provisions. If the coverage is for Level 1, and this is the first claim of the year, the deductible of \$500 will apply, leaving \$500. Coinsurance of 70% will result in plan payment of \$350. You will be financially responsible for the remainder of \$650. If the deductible has already been satisfied, and out-of-pocket limits have not been reached, the coinsurance of 70% will result in plan payment of \$700,

and you will be responsible for the remaining \$300.

If you are not eligible for Medicare when you retire, the Fund will be your primary coverage until you become eligible for Medicare. However, if your dependent is eligible for Medicare when you retire, even if you are not eligible for Medicare at that time, Medicare will provide your dependent's primary coverage, and the Fund will provide benefits as described above for your dependent.

Medicare has two parts -- Hospital Insurance (Part A) and Medical Insurance (Part B). Part A covers inpatient Hospital care and generally is available to all individuals over age 65 at no cost. Part B covers Physician services, outpatient Hospital services and other medical supplies and is optional. You must pay a monthly premium for Part B. To have adequate coverage, you and your Spouse must sign up for both Medicare Part A and Part B when eligible.

The Fund will pay benefits as if you have both Medicare Part A and Part B Benefits---whether you are signed up for them or not.

All medical claims after your enrollment in Medicare must be submitted to Medicare first. After Medicare pays the claim, submit a copy of the bill along with the Medicare Explanation of Benefits to the Fund Office.

Enrolling in Medicare

It is important that you or your eligible dependent visit an office of the Social Security Administration during the three-month period prior to the 65th birthday, or earlier if you are disabled, to learn all about Medicare. For questions on coverage by this Plan, or help in comparing benefits offered by this Plan and Medicare, please contact the Fund Office.

Remember, the Fund will pay benefits as if you have both Medicare Part A and Part B benefits -- whether you are signed up for them or not.

Cases Involving a Third Party

This Plan is not required to pay you or your dependent for an injury (including an illness) for which another party may be liable. The Plan may, however, advance benefits to the injured party (you or your dependent) while a third party's liability is being determined. You must notify the plan in writing as soon as the injured party institutes a claim against another person or entity, and the Fund Office will require the injured party to sign a Reimbursement/Subrogation acknowledgement form before any benefits are paid. If you, your dependent, if applicable, or your attorney refuse to sign a Reimbursement/Subrogation acknowledgement form, the plan may withhold payment of any benefits as a result of the injury cause by a third-party, and may recoup by offset or lawsuit any amount already paid.

Reimbursement

If you or your dependent should recover damages from an insurance company or from the other party (for example, in a lawsuit), then you must reimburse the Plan for the payments it has made or will make in connection with the injury. If you are injured by another party, you are required as a condition of receiving benefits from the Fund to sign a form acknowledging the Fund's right to recover under the terms of the Plan. The Fund's reimbursement right is established by the Plan and not by the acknowledgement form. In the event you receive benefits in such a case, the Fund's reimbursement interest in your recovery is governed by the terms of the Plan whether or not you have signed the acknowledgement form.

Under the terms of the Plan, the acceptance of benefits by a participant or dependent (or someone acting on his or her behalf) who has been injured by another party constitutes an agreement by the injured person to reimburse the Fund for benefits paid up to the full amount of the recovery due to the injury. The Fund has a right to first reimbursement out of any recovery whether or not the amounts recovered are designated to cover medical expenses. By accepting benefits from the Fund, the injured person agrees that any amounts recovered by the injured person by judgment, settlement or compromise will be applied first to reimburse the Fund, without reduction for attorney's fees or costs, even if the injured person is not made whole. Amounts recovered by the injured person in excess of benefits paid by the Fund are the separate property of the injured person. In addition, amounts received from an individual health insurance policy for which the injured person or a member of the injured person's family has paid premiums are also the separate property of the injured person. However, amounts received from a personal homeowner insurance policy, an automobile policy or a group insurance arrangement of any kind, regardless of whether the injured person or a member of the injured person's family has paid premiums on such policy or arrangement, are subject to the Fund's right to be reimbursed under this section.

By accepting benefits in excess of \$300 from the Fund for an injury for which another person may be liable, the injured person agrees to file a claim for benefits under any and all applicable policies of insurance, including but not limited to homeowner insurance, automobile insurance or any liability policy held for a public or commercial entity. The injured person agrees to notify the Fund promptly of efforts made to recover from a third party including filing a suit to recover amounts in connection with the injury. Furthermore, in the event the injured person or someone acting on his or her behalf receives payments from any source for claims related to the injury, the injured person agrees to notify the Fund promptly. By accepting benefits from the Fund the injured person agrees that neither the injured person nor anyone acting on behalf of the injured person will settle any claim relating to the accident or illness without the written consent of the Fund.

In the event an injured person accepts benefits from the Fund and amounts are recovered from claims arising from the injury, the amounts recovered are assets of the Fund by virtue of the Fund's reimbursement interest. Such Fund assets may not be distributed without a release from the Fund of its reimbursement interest.

In the event monies are recovered and the Fund is not reimbursed to the extent of its reimbursement interest in accordance with Plan provisions, the Fund may bring suit against the injured person, insurers and any recipients of the Fund assets improperly distributed without the consent of the Fund. The Fund may recover benefits paid on behalf of the injured person by treating such benefits as an advance and deducting such amounts from benefits which become due to the injured person and his or her immediate family until the Fund's subrogation interest is recovered. Such benefits may be deducted from amounts due to third parties who have provided medical services despite any certification of coverage that the Plan may have provided to such providers.

Subrogation

The Plan is not required to participate in an injured person's claims to demand reimbursement from an injured person or to invoke its subrogation rights. The Plan may request that the injured person assign or subrogate his or her claim or any other right of recovery to the Plan so that the Plan can enforce its right to recovery. The injured person must cooperate fully with the Plan in connection with any claim brought by the Plan to recover its assigned or subrogated interest. By accepting benefits from the Fund, the injured person authorizes the Fund to elect to pursue any claims arising from the injury in the name of the injured person and/or the Fund's name and to sue, compromise or settle such claims without the approval of the injured person to the extent of benefits paid and/or to be paid. If the injured person does not cooperate or if the injured person or any one acting on the injured person's behalf takes any action which harms the Plan's subrogated interest, the Plan is entitled to cease payment of any benefits connected to the third-party-caused injury, and recover from the injured person the amount of plan benefits paid. The Plan may bring a lawsuit against the injured person to collect payments already made or may collect these amounts by offset, against any future benefit payments otherwise due to the injured person and their immediate family. If legal proceedings are instituted the Plan may recover the costs and attorney's fees incurred.

Cases Involving Work-Related Claims

In general, the Welfare Fund does not cover expenses for an illness or injury that arises out of the course of employment. However, an exception exists if you have a work-related injury or illness for which a claim has been filed with a workers' compensation insurance carrier or with a federal or state court or agency. In the event that claim has been initially denied, then the Fund, upon request, may pay benefits arising from the work-related injury or illness.

By accepting these benefits from the Fund, you agree to actively pursue your work-related claim and also agree that the Fund has the power to institute, compromise or settle such a claim in your name to the extent of benefits paid. By accepting these benefits, you also agree that any amounts recovered by award, judgment, settlement or otherwise, and regardless of how the proceeds are characterized, are assets of the Fund and will be applied first to reimburse the Fund, in full and without any reduction for attorneys' fees or costs, for benefits paid due to the work-related claim. Once benefits are paid under this provision, you may not settle your work-related claim without the written consent of the Fund.

As a condition of receiving benefits from the Fund, you are required to sign a form acknowledging the Fund's right to reimbursement under the Plan. The Fund's right to reimbursement is established by the Plan and not by the form. The Fund's interest in your recovery is governed by the terms of the Plan whether or not you have signed the form. Therefore, the Plan has the rights described in this section even if you have not notified the Plan.

If monies are recovered and the Fund is not reimbursed to the extent of its interest in accordance with Plan provisions, the Fund may bring suit against you, any insurer and any recipients of the Fund assets improperly distributed without the consent of the Fund. The Fund may recover benefits paid on your behalf by treating such benefits as an advance and deducting such amounts from benefits which become due to you and your immediate family until the Fund's interest is recovered. Such benefits may be deducted from amounts due to third parties who have provided medical services despite any certification of coverage which the Plan may have provided to such providers.

Payment to Third Parties

Generally, benefits payable under the Plan cannot be alienated, transferred, assigned, or otherwise promised to a person or party other than the employee. However, there are some exceptions to this rule. You may direct that benefits payable to you be paid to an institution or provider of medical care that provided medical care for which benefits are payable under this Plan. However, the Fund is not obligated to accept such direction from you, and no payment by the Fund pursuant to your direction shall be considered as recognition by the Fund of a duty or obligation to pay a provider of medical care except to the extent to which the Fund actually chooses to do so. If there has been a benefit overpayment, or you otherwise owe money to the Fund, the Fund may choose to offset the overpayment against future benefits even if you have assigned those benefits to your Hospital or Physician. This is true even if the Fund has pre-certified coverage.

Additionally, should another group insurance or employee benefit plan pay benefits that are subsequently payable under this Plan, this Plan may reimburse the other benefit plan for the benefit that plan paid. Likewise, if you or a third party makes COBRA or other self-payments to this Plan that later become unnecessary because you gained eligibility under this Plan for that month, the Fund may reimburse the party making the premium payment.

All benefits under the Plan shall be exempt, to the extent permitted by law, from the claims of creditors and from all orders, decrees, garnishments, executions or other legal process or proceedings.

VII. Other Benefits

Your Life Insurance Plan of Benefits (Active Employees Only)

The Plan provides life insurance benefits for you and your eligible dependents as shown in the Summary of Benefits. If any portion of this section is inconsistent with the provisions of the insurance policy that provides these benefits, the insurance policy terms govern.

Death Benefits

Payments for the death of your eligible spouse or child are paid to you in a lump sum. If you are not living at the time of payment, the benefit is paid to your designated beneficiary.

If you die while you are an employee, a death benefit will be paid in a lump sum to your designated beneficiary based on the most recent form the Fund Office received prior to your death. You may name anyone you wish as your beneficiary and change your beneficiary at any time by filling out a new form. A divorce does not change your beneficiary or invalidate your beneficiary designation. If you are divorced and wish to change your beneficiary, you must submit a new form to the Fund Office.

Unless your beneficiary form provides otherwise:

- If more than one beneficiary is designated, they will share equally;
- If one beneficiary dies before you do, any remaining beneficiaries will share equally;
- If you do not name a beneficiary or if the persons named do not survive you, payment will be made to the surviving person or persons in the first of the following classes:
 - your spouse;
 - your children (or guardian, if a minor);
 - your parents; or
 - your estate.

If you and your spouse are both eligible employees under this Plan, you are separately entitled to death benefits as described above.

Disclaimer of Death Benefits

If a Beneficiary signs and delivers to the Fund Office a written disclaimer of Plan benefits which satisfies the requirements of §2518 of the Code and the Regulations thereunder, and the benefits, but for the disclaimer, would otherwise pass to such

individual as a result of the death of a Participant or a Beneficiary, the individual executing such disclaimer of benefits shall be deemed to have failed to survive the deceased Participant or Beneficiary from whom he otherwise would have taken. For such a disclaimer to be effective for purposes of the Plan, the following conditions must be satisfied:

- (a) The disclaimer must be an irrevocable and unqualified written refusal by the individual who would otherwise receive Plan benefits as a Beneficiary not to accept such benefits;
- (b) The written disclaimer must be received in the Fund Office no later than the date that is nine (9) months after the date of death of the Participant or Beneficiary by reason of which the disclaiming individual would be entitled to Plan benefits;
- (c) The disclaiming individual has not accepted any portion of the Plan benefits being disclaimed;
- (d) As a result of the disclaimer, the Plan benefits are paid in accordance with the Plan document and without any direction on the part of the individual making the disclaimer to a person other than the individual making the disclaimer, and
- (e) The disclaimer must satisfy the requirements of applicable state law which must be evidenced by an opinion of counsel for the disclaiming individual submitted with the disclaimer.

Accidental Death and Dismemberment

Accidental Death and Dismemberment (AD&D) Benefits are payable as shown in the Summary of Benefits. Benefits are payable if you sustain an accidental injury which results in the loss of life, a limb, or sight. Accidental Death and Dismemberment Benefits are not available to your dependents.

The following rules apply to Accidental Death and Dismemberment Benefits:

- For benefits to be paid, the loss must occur within 365 days of the date of the accident and be a direct result of bodily injury sustained from that accident independent of other causes.
- Brain Damage benefit will be paid if permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material functions of normal and everyday life manifests itself within 30 days of the accidental injury, the Employee requires hospitalization for at least 5 days and the brain damage persists for the 12 consecutive months after the injury.

- Loss of a hand or foot means severance at or above the wrist or ankle joint; for an eye, it means the total and irrecoverable loss of sight. The Plan does not pay for the loss of use of the hand and/or foot (but does pay for quadriplegia, paraplegia or hemiplegia).

Certain other benefits may be available under the terms of the insurance contract. Contact the Fund Office if you have questions about the current insurance contract coverage.

- Losses from the following circumstances are not covered:
 - physical or mental illness or infirmity;
 - infection, other than infection that occurs in an external, accidental cut or wound;
 - medical or surgical treatment (unless made necessary by an injury covered under the plan);
 - suicide or intentionally self-inflicted injury;
 - any act of war or injury while in military service for any country or international authority except the United States National Guard;
 - committing or attempting to commit a felony;
 - the voluntary intake or use by any means of 1) any drug, medication or sedative unless it is taken or used as prescribed by a physician or unless it is an “over the counter” drug taken as directed; 2) alcohol in combination with any drug, medication or sedative; or 3) poison, gas or fumes;
 - driving a vehicle or other device while intoxicated as defined by the laws of the jurisdiction in which the vehicle or device was being operated; or
 - riding in or descending from an aircraft as a pilot or crew member or in any capacity other than passenger; travel in an aircraft for the purpose of parachuting.

Loss of Benefits or Disability

Employee life insurance (but not AD&D) may be converted to individual coverage upon loss of eligibility as explained earlier. Life insurance (but not AD&D) is also continued until your 61st birthday if you are Totally Disabled as explained earlier in the Disability extension section.

Your Weekly Disability Income Benefits

Benefits are payable to eligible employees for periods of Disability caused by sickness or accident up to the amount shown in the Summary of Benefits.

Benefits are payable from the first day for an accident or confinement in a Hospital or from the eighth day of illness, whichever comes first. When outpatient surgery causes a disability that lasts more than one week, weekly disability benefits will be paid retroactively to the first day of disability. Injuries sustained on the job are not covered because these are covered by Worker's Compensation protection carried by each employer.

Successive Disability periods separated by less than two weeks of continuous active employment are considered as one continuous period of Disability unless they arise from different and unrelated causes.

You do not have to be confined to your home to collect benefits, but you must be under the care of a Physician. No Disability will be considered as beginning prior to your first visit to a Physician. You cannot receive benefits for any day on which you perform work of any kind, anywhere, for compensation or profit.

Weekly Disability Income Benefits are subject to taxes as are wages (unless you are permanently Disabled). Social Security taxes must be deducted from this payment.

Weekly Disability Income Benefits are payable only during a period of Disability. Once you recover from a Disability, you must notify the Fund Office of your recovery. If you receive Disability payments after your recovery, those payments must be returned to the Fund. If an overpayment is made for Disability payments during a period when you were not Disabled and you do not return these payments to the Fund, that amount (plus any reasonable interest charge that the Fund may impose) will be deducted from your next claim for benefits of any kind from this Fund.

The Fund, in determining whether you have been Disabled or if a Disability is continuing, reserves the right to request an updated medical report, or to require you to submit to a periodic physical examination at the Fund's expense by a medical doctor selected by the Fund. Your benefits may be terminated if you refuse to undergo a physical examination requested by the Fund.

Disability at Retirement

You cannot collect Weekly Disability Income Benefits and pension benefits at the same time. Weekly Disability Income Benefits may be used before the effective date of your retirement. Once you have retired, you cannot receive Weekly Disability Income Benefits unless you return to work and meet the eligibility requirements as a new employee.

VIII. How to File a Claim

For non-Medicare-eligible individuals, your Physician or Hospital is to submit claims directly to their local Blue Cross Blue Shield plan with the following information:

ID number - NMT followed by your Unique Identification Number (available from the Fund Office)

Group No. - P14560

Claims of Medicare-eligible individuals, non-medical claims (such as dental claims and non-VSP vision claims) are to be submitted directly to the Fund office at the following address:

NASMT Welfare Fund
8000 Corporate Drive
Landover, MD 20785

Prescription claims are typically completed by the local or mail-order pharmacy. Bring your prescription script from your doctor to your local pharmacy or, for prescriptions you will be taking for more than 60 days, mail your prescription script to the mail-order pharmacy (Express Scripts) using the form available on the Fund's website or by calling Express Scripts at 1-866-544-6775. Your local pharmacy will need information from your identification card to complete the claims process. If you exceed the two-fill (60 day) limit for prescription drugs at your local pharmacy, you can purchase the drug and submit the prescription receipt to the Fund office (or directly to Express Scripts) using the retail purchase reimbursement form available on the Fund's website.

For those eligible for Plan A benefits, Dental claims are filed directly with Delta Dental by participating dentists. Non-participating dentists and you may file industry standard claim forms for dental services in cases where the claim is not automatically filed by sending the claim to the following address:

Delta Dental
P. O. Box 2105
Mechanicsburg, PA 17055-2105

For those eligible for Plan A benefits, Vision claims must be filed by a participating Vision Service Plan ("VSP") provider. To find a VSP provider call VSP at 1-800-877-7195. If you obtain glasses and/or a visual acuity examination by a provider that is not a part of the Vision Service Plan, no coverage is available from the NASMT Welfare Fund.

Claim Forms - in General

The Fund office accepts industry standard claim forms. No special form is required for most claims. Here is a list of some of the Fund's forms and their associated use:

- Health Insurance Claim Form – used for Weekly Disability Income Benefits and

submission of prescription receipts purchased at the retail pharmacy.

- Attending Dentist's Statement – used both for obtaining a pre-treatment estimate of charges and for filing any Dental claim.
- Prescription mail order drug form – used to submit prescription scripts to Express Scripts.
- Prescription retail purchase reimbursement form – used to make claim for prescriptions purchased at the local pharmacy where you paid the full price for the prescription rather than just your co-insurance portion of the cost.
- Enrollment Form – used to enroll dependents and to update beneficiary information can be printed off the Fund's website or obtained by calling the Fund office
- Beneficiary Form – used to provide and to update beneficiary information.

Forms can be printed off the Fund's website or obtained by calling the Fund office.

Choosing a PPO Provider

Please contact the Fund Office, or refer to the Fund's web site (www.nasifund.org) to learn the name of your network Preferred Provider (PPO). Take advantage of the savings available through the PPO.

Instructions for Completing Forms

Fully complete the patient member information section of the claim form. Claim forms with missing information will delay processing and payment. Your phone number and area code are important. If written confirmation is not required, the Fund can resolve any details with you promptly on the telephone.

Follow the general information guidelines below when a claim occurs.

If a confinement becomes necessary, follow the procedures and present your Identification Card upon admission. The Hospital can verify eligibility and coverage by calling the numbers printed on the back of the Identification Card. The patient (or parent if a minor) must sign, authorizing the release of information to the Welfare Fund. You should only sign authorization of the Fund to pay benefits directly to the Physician if that is your arrangement with your Physician. In lieu of filling out the physician section of the claim form, your Physician can send an itemized bill to the Fund.

Prescription drug receipts must show the following information:

- the name of the patient
- the prescribing Physicians

- the pharmacy prescription number
- the date filled
- the amount billed
- the quantity of the drug
- the NDC #

Life and Accidental Death Claims

You need to submit a certified copy of the death certificate. In the case of accidental death, a police report or newspaper account of the accident will assist resolution of the claim.

Mailing of Claim Forms

All forms should be mailed to the Fund Office address shown on the claim form or inside the front cover of this booklet.

Claims Filing Deadline

Claims must be filed within two years from the date covered services are provided or they will not be considered.

IX. Claims and Appeals Procedures and Requests for Pre-Service Evaluations

Claims Procedure for Health Care Claims

The following procedures apply to health care claims (i.e., health, dental and vision claims) except that this procedure does not apply to optional pre-service evaluations of a Hospital admission (see page 40) and optional pre-service evaluations of medical services (see pages 85 and 86). Please note that the Plan intends to follow all applicable legal requirements when adjudicating benefit claims, and decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to an individual such as a claims adjudicator or medical expert will not be based upon the likelihood that the individual will support the denial of benefits.

After you file a claim for benefits, the Fund Office will generally notify you of its benefit determination within 30 days after receiving your claim. The Fund Office will seek extensions beyond the 30-day period only for circumstances that are beyond the control of the Fund Office. If the Fund Office determines an extension is appropriate, the initial 30-day period may be extended by an additional 15 days, provided that the Fund Office notifies you of the extension prior to the expiration of the initial 30-day period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Fund Office expects to decide your claim. If the initial 30-day period of time is extended due to your failure to submit information necessary to decide a claim, the written notification described above will set forth the specific information required from you, and you will have at least 45 days to provide the requested information. In that case, the Plan's time for making a benefit determination is tolled from the date the Fund Office sends you an extension notification until the date you respond to the request for additional information or your time to respond expires. If you provide additional information in response to such a request, a decision will be rendered within 15 days of when the information was received by the Plan.

If your application for benefits is denied in whole or in part or if there is a rescission of your coverage, the Fund Office will provide you with a written or electronic notice, which sets forth:

1. sufficient information to identify the claim involved, including where applicable, the date of service of the benefits denied, the health care provider, the claim amount, and the right to receive upon request the diagnosis code, treatment code and the meanings of these codes;
2. the reason(s) for the denial of the claim (including the denial code and its corresponding meaning) or rescission;
3. a description of any standard used to deny your claim;

4. references to the specific plan provisions on which the benefit determination or rescission was based;
5. if an internal rule or guideline was relied upon in denying your claim or rescinding your coverage, either a copy of the rule or guideline or a statement that you have the right to receive a free copy of the internal rule or guideline upon request;
6. if the denial is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to your medical circumstances, or a statement that this will be provided free of charge upon request;
7. a description of any additional material or information which might help your claim (including an explanation of why that information may be helpful);
8. a description of any internal or external appeals available, how to initiate them and applicable filing deadlines, including the right to bring a civil legal action under ERISA if the claim continues to be denied on review;
9. a statement that you or your representative, may submit information in support of your claim in writing upon filing a request for review of denial of benefits or a rescission;
10. 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; and
11. disclosure of the availability of, and the contact information for, an applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

The Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, as soon as practicable after receiving a request. The Plan will not consider a request for such diagnosis and treatment information, in itself, to be an appeal.

A “rescission” of coverage is a retroactive cancellation or termination of your coverage. The Plan may rescind coverage if the person whose coverage is rescinded (or the person through whom coverage of a dependent is obtained) performs an act, practice or omission that constitutes fraud or if the individual makes an intentional misrepresentation of material fact. Termination of coverage for failure to pay a premium, including a COBRA or self-pay premium, or to have contributions made on an individual’s behalf is not a rescission. Likewise, termination of coverage retroactive to the date of divorce (or other event making a dependent ineligible for coverage) is not a “rescission” where the Fund Office is not notified of a divorce or other disqualifying event and COBRA is not elected and/or the full COBRA premium is not paid by the employee or ex-spouse for coverage. Prospective termination is not a rescission. The Fund must provide 30-days notice to each participant who would be affected by the rescission before a rescission can occur.

Appeals Procedure for Denied Health Care Claims

If you receive a notice that your health care claim for benefits has been denied in whole or in part, or if there has been a rescission of your coverage you may submit a written appeal to the Trustees, requesting that the Board of Trustees review your benefit denial, rescission of coverage or the Fund policy, determination or action with which you disagree. Your written appeal must be submitted within 180 days of receiving the notice of denial of benefits or rescission of coverage. An appeal should be sent to:

Board of Trustees
National Automatic Sprinkler Metal Trades Welfare Fund
8000 Corporate Drive
Landover, MD 20785

Your written appeal should state the reason for your appeal. This does not mean that you are required to cite all applicable Plan provisions or to make "legal" arguments; however, you should state clearly why you believe you are entitled to the benefit you claim or why you are entitled to restoration of your coverage following a rescission. You are permitted to submit written comments, documents, records and other information relating to your claim even if such information was not submitted in connection with your initial claim for benefits. The Trustees can best consider your position if they clearly understand your claims, reasons and/or objections. Upon request, you will also have access to, and the right to obtain free copies of, all documents, records and information relevant to your claim.

The Trustees, or a designated Committee of the Trustees, will conduct a full review of all the information that you submit in connection with your appeal. Neither the Trustees nor any member of a Committee designated by the Trustees, nor a subordinate thereof, will have been involved in the initial benefit determination. You are entitled to review the Plan's claim file and to present evidence and testimony in support of your claim. The decision on appeal will not give deference to the initial denial. The Fund Office will provide you (free of charge) with new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for you to respond to such new evidence or rationale.

If the initial denial was based, in whole or in part, on a medical judgment, the Trustees shall consult with a medical professional who has appropriate training and experience in the relevant field of medicine relating to the appeal. The medical professional will be an individual who was not consulted, and is not the subordinate of any professional consulted, in connection with the initial denial. You have the right to learn the identity of any health care professional contacted in connection with your claim.

The Trustees, or a designated Committee of the Trustees, will review your appeal at their quarterly meeting immediately following receipt of your appeal, unless the Fund Office receives your appeal within 30 days before the date of the meeting. In that case, your appeal will be reviewed at the second quarterly meeting following receipt of the appeal. You may wish to

contact the Fund Office concerning the date of the next meeting, so that you may submit your appeal in time to be heard at that meeting. If special circumstances require an extension of time for reviewing your claim, you will be notified in writing of the need for the extension. The notice will be provided prior to the commencement of the extension, will describe the special circumstances requiring the extension and will set forth the date the Trustees will decide your appeal. Such date will not be later than the third meeting of the Trustees or Committee following the Fund Office's receipt of your appeal. Once your claim has been reviewed and a benefit determination has been made, you will receive a written or electronic notice of the decision within 5 days. If your claim is denied, you will receive a written notification that contains the following information:

1. sufficient information to identify the claim involved, including where applicable, the date of service of the benefits denied, the health care provider, the claim amount, and the right to receive upon request the diagnosis code, treatment code and the meanings of these codes;
2. the reason(s) for the denial of the claim (including the denial code and its corresponding meaning) and a discussion of the decision or rescission;
3. a description of any standard used to deny your claim;
4. references to the specific plan provisions on which the benefit determination or rescission was based;
5. if an internal rule or guideline was relied upon in denying your claim or rescinding your coverage, either a copy of the rule or guideline or a statement that you have the right to receive a free copy of the internal rule or guideline upon request;
6. if the denial is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to your medical circumstances, or a statement that this will be provided free of charge upon request;
7. the identification of any medical or vocational experts whose advice was obtained in connection with the benefit determination, regardless of whether the advice was relied upon in making the benefit determination;
8. 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;
9. a description of the external review process, including information on how to initiate an external review and applicable time limits, and the right to bring a civil legal action under ERISA;

10. A statement describing any voluntary alternative dispute resolution options that may be available by contacting the U.S. Department of Labor, and the right to bring a civil legal action under ERISA; and
11. disclosure of the availability of, and the contact information for, an applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

The Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, as soon as practicable after receiving your request. The Plan will not consider a request for such diagnosis and treatment information, in itself, to be a request for an external review.

External Review of an Adverse Health Care Benefit Determination after Appeal

These procedures apply to health care claims (i.e., health, dental and vision claims) that are denied on appeal. They are intended to comply with the interim safe harbor contained in U.S. Department of Labor Technical Release 2010-01. At such time that guidance is revised or replaced by the Department, the new guidance shall be incorporated by reference herein and these procedures will be superseded by such new guidance to the extent necessary to comply with the Patient Protection and Affordable Care Act (“PPACA”).

If you receive an adverse benefit determination on your appeal concerning your health care claim or a rescission of your coverage, you have the right to request an external review. The request should be sent to the address identified above for submitting an appeal to the Trustees. Your request for an external review must be made no later than four (4) months after the date you receive the adverse decision on your appeal. If there is no corresponding date four (4) months after the date of receipt of such notice, the request must be filed by the first day of the fifth (5th) month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is not February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday.

Within five (5) business days following receipt, the Fund Office will make a preliminary review to determine whether:

1. You are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
2. The adverse benefit determination or the final adverse benefit determination does not relate to your failure to meet the requirements for eligibility to participate under the terms of the Plan (eligibility claims are not subject to external review);
3. You have exhausted the Plan’s internal appeal process unless you are not required to exhaust the final internal appeals process; and

4. You have provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the Fund Office will issue a written notification to you. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and the toll-free (if available) contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete. The Plan will allow you to perfect the request for external review within the later of: (a) the four-month filing period, or (b) the 48 hour period after the receipt of notification.

If your case is eligible for external review, it will be forwarded to an Independent Review Organization (IRO) accredited by a nationally-recognized accrediting organization, and the IRO will contact you. The Fund Office will contract with at least three (3) IROs for assignments under the Plan and rotate claim assignments among them or incorporate other independent, unbiased methods for selection of IROs, such as random selection.

With respect to claims for which an adverse benefit determination has not been initiated by September 20, 2011, the Federal external review process applies only to:

1. An adverse benefit determination (including a final adverse benefit determination) by the Plan that involves medical judgment (including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or the Plan's determination that a treatment is experimental or investigational), as determined by the external reviewer. Additional examples of situations where a claim is considered to involve medical judgment include adverse benefit determinations based on:
 - a. The appropriate health care setting for providing medical care to an individual (such as outpatient versus inpatient care or home care versus rehabilitation facility);
 - b. Whether treatment by a specialist is medically necessary or appropriate (pursuant to the Plan's standard for medical necessity or appropriateness);
 - c. Whether treatment involved "emergency care", affecting coverage or the level of coinsurance;
 - d. A determination that a medical condition is a preexisting condition;
 - e. The Plan's general exclusion of an item or service, if the Plan covers the item or service in certain circumstances based on a medical condition;
 - f. Whether a participant or beneficiary is entitled to a reasonable alternative standard for a reward under the Plan's wellness program, if any;
 - g. The frequency, method, treatment, or setting for a recommended preventive service, to the extent not specified, in the recommendation or guideline of the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the Health Resources and Services Administration (as described in PHS Act section 2713 and its implementing regulations); and
 - h. Whether the Plan is complying with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act and its

- implementing regulations, which generally require, among other things, parity in the application of medical management techniques;
2. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Once you are contacted by the IRO, you will have ten business days to submit additional information directly to the IRO if you choose to do so. The IRO is not required to, but may accept and consider additional information submitted after ten (10) business days. The IRO will use legal experts where appropriate to make coverage determinations under the Plan. Within five (5) business days after the assignment of the IRO, the Fund Office will provide to the IRO the documents and information considered in making the adverse benefit determination or final internal appeal including information that you previously submitted to the Fund Office. Failure by the Fund Office to timely provide the documents and information will not delay the conduct of the external review. If the Fund Office does not timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one (1) business day after making such a decision, the IRO must notify you and the Plan.

Upon receipt of any information that you submit, the IRO must forward the information to the Plan within one (1) business day. The Fund Office may, but is not required to, reconsider its adverse benefit determination or final internal adverse benefit determination. Reconsideration by the Plan will not delay the external review. If the Fund Office decides to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment, the Fund Office will provide written notice of its decision to you and the IRO within one (1) business day after making its decision. The IRO will terminate the external review upon receiving this notice from the Fund Office.

The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

1. Your medical records;
2. The attending health care professional's recommendation;
3. Reports from appropriate health care professionals and other documents submitted by you, your treating provider, the Plan or issuer;
4. The terms of the Plan to ensure that the IRO's decision is not contrary to the Plan's terms, unless the terms are inconsistent with applicable law;

5. Appropriate practice guidelines, which must include applicable evidence based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
6. Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the Plan's terms or with applicable law; and
7. The opinion of the IRO's clinical reviewer or reviewers after considering the available information or documents to the extent the clinical reviewer or reviewers consider appropriate.

Within 45 days after the IRO receives your request for external review from the Fund Office, the IRO will issue to you a written notice of its final external review decision. The written decision of the IRO will contain:

1. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), and the reason for the previous denial);
2. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
3. References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;
4. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
5. A statement that the determination is binding except to the extent that other remedies may be available under the State or federal law to either the group health plan or to you;
6. A statement that judicial review may be available to you;
7. current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

Upon receipt of a notice of final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim. The IRO's decision is binding on you and the Plan, except to the extent other remedies are available under State or Federal law, and except that the requirement that the decision be binding shall not preclude the Plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denied the claim or otherwise fails to require such payment or benefits. For this purpose, the Plan must provide any

benefits, including by making payment on the claim, pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited External Review: When external review is otherwise available, the Plan will allow you to make a request for an expedited external review at the time you receive:

1. An adverse benefit determination on appeal involving a medical condition for which the timeframe to complete a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal, or
2. A final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency care services, but have not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, the Fund Office will review the request to determine whether the request meets the reviewability requirements using the same criteria above that apply to a standard external review. The Plan will immediately send a notice of its eligibility determination that meets the requirements above for a standard external review eligibility determination notice.

Upon determination that request is eligible for expedited external review following the preliminary review, the Fund Office will assign an IRO in accordance with the requirements for assigning an IRO for a standard external review above. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefits determination to the assigned IRO electronically or by telephone or fax or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard external review. In reaching a decision, the IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The IRO will provide written notice to you and the Plan of the final external review decision, in accordance with the requirements above for standard external review, except that the notice will be provided as expeditiously as possible, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, then within 48 hours after the date of providing that notice, the IRO must provide written confirmation of that decision to you and the Plan

If the IRO reverses the Plan's adverse benefit determination or final internal adverse benefit determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim. The IRO's decision is binding on you and the Plan, except to the extent other remedies are available under State or Federal law, and except that the requirement that the decision be binding shall not preclude the Plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denied the claim or otherwise fails to require such payment or benefits. For this purpose, the Plan must provide any benefits, including by making payment on the claim, pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

IROs must maintain records of all claims and notices associated with the external review process for six (6) years. An IRO must make such records available for examination by you, the Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Procedures for Optional Pre-Service Evaluation of Hospital Admissions

The Fund urges you to obtain evaluation of Hospital admissions (see page 41) and provides these special optional procedures for such requests. A purpose for this evaluation is to inform you regarding the likelihood as to whether the contemplated admission meets the Plan's medical necessity standard and other Plan requirements for coverage. Although an advance determination is not required for you to obtain medical care, it may be advisable to obtain information whether coverage for a contemplated procedure may be denied because it is experimental or might otherwise not be covered by the Plan.

For all requests for evaluation of Hospital admissions, the initial request is made by calling a Medical Review Specialist with American Health (our Utilization Review/Case Management firm) at 1-866-343-3709. For such inquiries, American Health will notify you of its evaluation within 30 days after receiving your inquiry. If the initial 30-day period of time needs to be extended due to a failure to provide American Health with the information it needs to make an evaluation, you will be notified of the specific information American Health needs, and you or your medical care provider will have at least 45 days to provide the requested information.

It is important to remember that an evaluation by American Health is not a denial of benefits. It is an optional service provided by the Plan to enable you to obtain an evaluation whether a particular hospital admission is likely to be covered by the Plan. If the evaluation is negative, you are still free to obtain the services and submit a claim which will be evaluated based on the actual information submitted in support of the claim and not the information submitted for the advance evaluation.

Procedures for Optional Pre-Service Evaluation of Medical Services

The Fund provides the opportunity for optional pre-service evaluation of Medical Services and provides these special procedures for such requests. A purpose for this evaluation is to inform

you regarding the likelihood as to whether the contemplated medical procedure or service meets the Plan's medical necessity standard and other Plan requirements for coverage. Although an advance determination is not required for you to obtain medical care, it may be advisable to obtain information whether coverage for a contemplated procedure may be denied because it is experimental or might otherwise not be covered by the Plan.

For all requests for evaluation of Medical Services, the initial request may be made by calling the Fund Office as speaking to a Claims Service Representative at 1-800-638-2603 or by email request to mail@nasifund.org or by writing to:

Claims Department
National Automatic Sprinkler Metal Trades Welfare Fund
8000 Corporate Drive
Landover, MD 20785

For such requests for evaluation the Fund Office will notify you of its evaluation within 30 days after receiving your inquiry. If the initial 30-day period of time needs to be extended due to a failure to provide the Fund Office with the information it needs to make an evaluation, you will be notified of the specific information needed, and you or your medical care provider will have at least 45 days to provide the requested information.

It is important to remember that an evaluation by the Fund Office is not a denial of benefits. It is an optional service provided by the Plan to enable you to obtain an evaluation whether particular medical services are likely to be covered by the Plan. If the evaluation is negative, you are still free to obtain the services and submit a claim which will be evaluated based on the actual information submitted in support of the claim and not the information submitted for the advance evaluation.

Claims Procedures for Disability Claims

After you file a claim for benefits, the Fund Office will generally notify you of its decision within a reasonable period of time, but not later than 45 days after it receives the claim. However, if the Fund Office determines that special circumstances require an extension of time for processing the claim, the Fund Office will notify you, in writing and before the end of the initial period, that it will need additional time to decide the claim. The Fund Office will seek extensions beyond the 45-day period only for circumstances that are beyond the control of the Fund Office. If the Fund Office determines an extension is appropriate, the initial 45-day period may be extended by an additional 30 days, provided that the Fund Office notifies you of the extension prior to the expiration of the initial 45-day period. The extension notice will:

1. indicate the special circumstances requiring an extension of time;
2. set forth the date by which the Fund Office expects to decide your claim;
3. explain the standards on which entitlement to a benefit is based;

4. describe the unresolved issues that prevent the claim from being decided;
5. specify the additional information that may be needed to decide your claim; and
6. provide you with at least 45 days within which to provide the specified information.

If 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 by the Fund Office 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 or your time to respond expires. If you provide additional information in response to such a request, a decision will be rendered within 15 days of when the information was received by the Plan.

If the Fund Office decides that it is unable to decide your claim during the first 30-day extension due to matters beyond its control, a second 30-day extension is possible. In the event that a second 30-day extension is required, the Fund Office will notify you of the extension prior to the expiration of the initial 30-day extension period and the notification will contain the same information required to be included in the first notice.

If your application for benefits is denied in whole or in part, the Fund Office will provide you with a written or electronic notice that sets forth:

1. the reason(s) for the denial;
2. references to any pertinent Plan provisions, internal rules, guidelines, protocols or other criteria relied on in making the adverse determination;
3. a description of any additional materials or information which might help your claim (including an explanation of why that information may be helpful);
4. a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for benefits;
5. a description of the appeals procedures and applicable filing deadlines, including the right to bring a civil legal action under ERISA if the claim continues to be denied on review; and
6. if the determination is based on an internal rule, guideline, protocol, or other similar criterion, a statement that such a rule, guideline, protocol, or criterion was relied upon in making the denial, along with either a copy of the specific rule, guideline, protocol, or criterion, or a statement that a copy will be provided to you free of charge upon request.

Appeals Procedures for Disability Claims

If your disability claim is denied, you may submit a written appeal to the Trustees, requesting that the Board of Trustees review your benefit denial. Your written appeal must be submitted within 180 days of receiving the notice of denial of benefits. Your appeal should be sent to:

Board of Trustees
National Automatic Sprinkler Metal Trades Welfare Fund
8000 Corporate Drive
Landover, MD 20785

Your written appeal should state the reason for your appeal. This does not mean that you are required to cite all applicable Plan provisions or to make "legal" arguments; however, you should state clearly why you believe you are entitled to the benefit you claim. You are permitted to submit written comments, documents, records and other information relating to your claim even if such information was not submitted in connection with your initial claim for benefits. The Trustees can best consider your position if they clearly understand your claims, reasons and/or objections.

The Trustees, or a designated Committee of the Trustees, will review your appeal at their quarterly meeting immediately following receipt of your appeal, unless the Fund Office received your appeal within 30 days of the date of the meeting. In that case, your appeal would be reviewed at the second quarterly meeting following receipt of the appeal. You may wish to contact the Fund Office concerning the date of the next meeting, so that you may submit your appeal in time to be heard at that meeting. If special circumstances require an extension of time for reviewing your claim, you will be notified in writing of the need for the extension. The notice will be provided prior to the commencement of the extension, describe the special circumstances requiring the extension and set forth the date the Trustees will decide your appeal. Such date will not be later than the third meeting of the Trustees or Committee following the Fund Office's receipt of your appeal.

Neither the Trustees nor any member of a Committee designated by the Trustees, nor a subordinate thereof, will have been involved in the initial benefit determination. The Trustees, or the designated Committee of the Trustees, will give no deference to the initial claim denial. Additionally, if the initial denial was based, in whole or in part, on a medical judgment, the Trustees shall consult with a medical professional who has appropriate training and experience in the relevant field of medicine relating to the appeal. The medical professional will be an individual who was not consulted, nor is the subordinate of any professional consulted, in connection with the initial denial. You have the right to learn the identity of any health care professional contacted in connection with your claim.

Once your claim has been reviewed and a benefit determination has been made, you will receive written or electronic notice of the decision within 5 days. If your appeal is denied, the notice will be written in a manner calculated to be understood by you and will include:

1. the specific reason(s) for the adverse determination;
2. references to the specific Plan provisions on which the determination was based;

3. a statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request;
4. if the determination was based on an internal rule, guideline, protocol, or other similar criterion, a statement that such a rule, guideline, protocol, or criterion was relied upon in making the denial, along with either a copy of the specific rule, guideline, protocol, or criterion, or a statement that a copy will be provided to you free of charge upon request;
5. a statement describing your right to bring a civil legal action under ERISA.

Claims Procedure for Life, Accidental Death and Dismemberment Claims, and Claims Relating to Fund Policy Changes, Determinations or Actions

The following procedure applies to claims not covered by the claims procedures for health care or disability claims set forth above. For example, the procedure applies to claims for life insurance or accidental death and dismemberment insurance benefits, and claims related to a Fund policy change, determination, or action (including an eligibility determination) with which you disagree that is not a benefits denial or rescission of coverage. With respect to claims for eligibility to participate in health care or disability benefits, this procedure applies if you are inquiring solely about eligibility to participate in those programs. Claims involving both an eligibility determination and a current claim for benefits for health care or disability benefits are subject to the benefits claims procedures for those programs, described above.

After you file a claim, the Fund Office will generally notify you of its decision within a reasonable period of time, but not later than 90 days after it receives the claim. However, if the Fund Office determines that special circumstances require an extension of time for processing the claim, the Fund Office will notify you, in writing and before the end of the initial period, that it will need additional time to decide the claim. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Fund Office expects to decide your claim. For claims, such date will not exceed 90 days from the end of the initial 90-day period.

If your claim is denied in whole or in part, the Fund Office will provide you with a written notice that:

1. explains the reason or reasons for the decision;
2. includes specific references to Plan provisions upon which the decision is based;
3. provides a description of any additional material or information that might be helpful to decide the claim (including an explanation of why that information might be necessary);

4. include a statement that you are entitled to receive, upon request and free of charge, reasonable access to , and copies of, all Plan documents, records, and other information relevant to the claim for benefits; and
5. describes the appeals procedures and applicable filing deadlines, including the right to bring a civil legal action under ERISA if the claim continues to be denied on review.

Appeals Procedure for Life, Accidental Death and Dismemberment Claims, and Claims relating to Fund Policy Changes, Determination or Actions

If you disagree with the decision reached by the Fund Office, you may submit a written appeal requesting a review of the decision. The written appeal must be submitted within 60 days of receiving the initial adverse decision. The appeal should clearly state the reason or reasons why you disagree with the Fund Office's decision. You may submit written comments, documents, records and other information relating to the claim even if such information was not submitted in connection with the initial claim for benefits. Additionally, upon request and free of charge, you may have reasonable access and copies of all Plan documents, records and other information relevant to the claim.

The Fund Office will generally notify you of its decision on appeal within 60 days after the appeal is received, unless special circumstances require an extension of time for processing, in which event a decision should be rendered as soon as possible, but in no event later than 120 days after such receipt. The decision will be in writing and will include:

1. specific reasons for the decision, with specific references to the pertinent Plan provisions on which the decision is based;
2. 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 the claim;
3. a statement describing your right to bring a civil legal action under ERISA.

Statute of Limitations and Exhaustion of Administrative Remedies

You may not commence a judicial proceeding against any person, including the Plan, a Plan fiduciary, the Plan Administrator, the Plan Trustees, the Fund Office, or any other person, with respect to a claim for health care, disability, life insurance, accidental death and dismemberment insurance, fund policy changes, determination or actions, or other claims for benefits without first exhausting the appropriate claims procedures set forth above. If you have exhausted these procedures and are dissatisfied with the decision on appeal of a denied claim, you may bring an action under Section 502 of ERISA in an appropriate court to review the Plan's decision on appeal, but only if the action is commenced no later than the earlier of (1) the applicable statute of limitations, or (2) the second anniversary of the date of the decision on appeal.

In the case of health plans subject to the expanded claims procedure requirements under PPACA, then notwithstanding the previous paragraph, if the Plan fails to adhere to all of the requirements of the procedures set forth above for health Plan claims or rescissions of health Plan coverage, then to the extent mandated by PPACA, you may initiate an external review or bring an action in an appropriate court under state law or section 502(a) of ERISA, but only if the action is commenced no later than the earlier of (1) the applicable statute of limitations, or (2) the second anniversary of the date of the decision in the external appeal. However, you cannot initiate an external review or bring an action in an appropriate court under state law or section 502(a) of ERISA without first exhausting the claims procedures set forth above if the violation by the Plan was:

1. De minimis;
2. Not likely to cause you prejudice or harm;
3. Attributable to good cause or matters beyond the Plan's control;
4. In the context of an ongoing good-faith exchange of information; and
5. Not reflective of a pattern or practice of non-compliance by the Plan.

Within 10 days of the Plan's receipt of your written request, you are entitled to an explanation of the Plan's basis for asserting that it meets the above exception that includes a specific description of its bases, if any, for asserting the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects your request for immediate review on the basis that the Plan met the requirements for the exception, then the Plan will provide you with notice of the opportunity to resubmit and pursue the internal appeal of the claim within a reasonable time after the external reviewer or court rejected the claim for immediate review (but not to exceed ten days). Time periods for re-filing the claim shall begin to run upon your receipt of such notice.

You may only renew your appeal if you have any material additional information or new arguments to present. A renewed appeal will only consider the impact of the new information or new arguments, must be submitted in writing, and the rules and limits stated above apply. In connection with an appeal or a renewed appeal, you may review pertinent documents in the Fund Office after making appropriate arrangements, or you may request that documents be provided to you. Such information will be provided free of charge.

X. General Information/ERISA Rights

The following information is provided as specified in the Employee Retirement Income Security Act of 1974 (ERISA).

Official Name of Plan:

National Automatic Sprinkler Metal Trades Welfare Fund

Type of Administration:

Collectively bargained, joint-trusted labor management trust; self-administered.

Type of Plan:

Hospitalization, Medical, Disability, Dental, Vision, Death and Accidental Death and Dismemberment.

Name and Address of the Administrator, the Plan Office, and the Person Designated as Agent for the Service of Legal Process:

Michael W. Jacobson, Fund Administrator
National Automatic Sprinkler Metal Trades
Welfare Fund
8000 Corporate Drive
Landover, MD 20785

In addition, service of Legal process may be made on any Plan Trustee.)

Names, Titles and Addresses of the Plan Trustees:

Union Trustees

John D. Bodine, Sr.
Sprinkler Fitters Local 669
7050 Oakland Mills Rd.
Suite 200
Columbia, MD 21046

Shawn Broadrick
Sprinkler Fitters Local 669
7050 Oakland Mills Road
Suite 200
Columbia, MD 21046

James E. Tucker
Sprinkler Fitters Local 669
7050 Oakland Mills Road
Suite 200
Columbia, MD 21046

Employer Trustees

Cornelius J. Cahill
National Fire Sprinkler Association, Inc.
Robin Hill Corporate Park
Route 22, P.O. Box 1000
Patterson, NY 12563

Jim Lynch
National Fire Sprinkler Association, Inc.
Robin Hill Corporate Park
Route 22, P.O. Box 1000
Patterson, NY 12563

Fred Barall
National Fire Sprinkler Association, Inc.
Robin Hill Corporate Park
Route 22, P.O. Box 1000
Patterson, NY 12563

Source of Financing of the Plan and Identity of Any Organization Through Which Benefits are Provided:

Payments are made to the trust by individual employers under the provisions of Collective Bargaining Agreements, by retirees and employees through self-payments. Income is earned from investment of contributions. All monies are used exclusively for providing benefits to eligible employees and their dependents and for expenses incurred with respect to the operation and administration of the Plan.

The Fund Office will provide you, upon written request, information as to whether an employer is contributing to this Fund on behalf of employees working under a Collective Bargaining Agreement.

The Plan has arrangements with various organizations such as preferred provider networks that affect the payment of benefits. The following is a list of those organizations and the services they provide to the Plan.

Utilization Review/Case Management

American Health Holding, Inc.
100 West Old Wilson Bridge Road
Worthington, OH 43085
(866)343-3709

Preferred Provider Organization

Blue Cross Blue Shield
300 East Randolph Street
Chicago, IL 60601
(312) 653-8365

Prescription Drug Program

Express Scripts
1 Express Way
St. Louis, MO 63121
(314) 996-0900

Accidental Death and Dismemberment Insurance; Life Insurance

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156
(800) 872-3862

All other benefits are administered under the direction of the Trustees. Except as indicated above, no other payments provided for in this Plan are insured by any contract of insurance other than through a stop-loss contract, and there is no liability on the Board of Trustees or any other individual or entity to provide payment over and beyond the amount in the Fund. The Trustees, in their sole discretion, have the right to interpret, terminate, suspend, withdraw, amend or modify the Plan and any of its provisions, in whole or in part, at any time, including the existence and duration of coverage for all employees, retirees, and eligibility and requirements for coverage, the availability, nature and extent of benefits and conditions for and method of payment of benefits.

Date of the End of the Plan Year: December 31

Internal Revenue Service Plan Identification Number:
23-7351551

The Plan Number is:
501

Plan Termination; Amendment or Elimination of Benefits; Interpretation of Plan:

The Fund may be terminated by a document in writing adopted by the Trustees. The Fund may be terminated if, in the opinion of the Trustees, the Trust Fund is not adequate to carry out the intent and purpose of the Fund as stated in its Trust Agreement, or is not adequate to meet the payments due or which may become due under the Plan of Benefits. The Fund may also be terminated if there are no individuals living who can qualify as Employees or Beneficiaries under the Plan. Finally, the Fund may be terminated if there are no longer any Collective Bargaining Agreements requiring contributions to the Fund. The Trustees have complete discretion to determine when and if the Fund should be terminated.

If the Fund is terminated, the Trustees will: (a) pay the expenses of the Fund incurred up to the date of termination as well as the expenses in connection with the termination; (b) arrange for a final audit of the Fund; (c) give any notice and prepare and file any reports which may be required by law; and (d) apply the assets of the Fund in accordance with the Plan of Benefits including amendments adopted as part of the termination until the assets of the Fund are distributed.

No part of the assets or income of the Fund will be used for purposes other than for the exclusive benefit of the employees and the beneficiaries or the administrative expenses of the Fund. Under no circumstances will any portion of the Fund revert or inure to the benefit of any contributing employer, the Association or the Union either directly or indirectly.

Upon termination of the Fund, the Trustees will promptly notify the Union, the Association, employers, and all other interested parties. The Trustees will continue as Trustees for the purpose of winding up the affairs of the Fund.

In addition, the Trustees have complete discretion to interpret, amend or modify the Plan and any of its provisions, in whole or in part, at any time. This means that the Trustees can reduce or eliminate benefits or modify the availability, nature and extent of benefits and conditions for and method of payment of benefits. The Trustees may also modify length of coverage for all employees, dependents and retirees, and eligibility requirements for coverage.

ERISA RIGHTS STATEMENT

As a participant in the National Automatic Sprinkler Metal Trades Welfare Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits 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 preexisting conditions under a subsequent group health plan, if you have creditable coverage from this Plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in 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 that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen

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

Assistance with 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, you should contact the nearest office of the Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.

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