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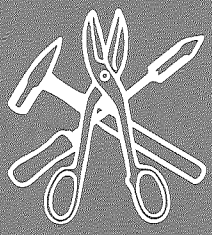

SHEET METAL WORKERS' HEALTH PLAN OF SOUTHERN CALIFORNIA, ARIZONA AND NEVADA

RETIREE HEALTH PLAN

SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT FOR MEDICARE SUPPLEMENT OPTION AND FEE-FOR-SERVICE COMPREHENSIVE MEDICAL OPTION

MEDICAL AND PRESCRIPTION DRUG BENEFITS FOR RETIRED PARTICIPANTS AND ELIGIBLE DEPENDENTS ENROLLED IN THE MEDICARE SUPPLEMENT OPTION OR FEE-FOR-SERVICE COMPREHENSIVE MEDICAL OPTION

REVISED JULY 1, 2017

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QUICK REFERENCE CHART

HEALTH PLAN ADMINISTRATIVE OFFICE	
• **Questions about retiree eligibility or general information** • **Questions about eligibility for dependents** • **Questions about return to work policies** • **Questions about retiree self-pay rates** • **Questions about medical benefits or claims** • **Replacement of ID cards, general assistance, contact the Plan Administrative Office** • **HIPAA Privacy Notice, Privacy & Security Officers**	**800-947-4338** **or visit the Plan's website:** **www.sheetmetalsam.org** **Mailing address:** **Sheet Metal Workers' Health Plan** **P.O. Box 10067** **Manhattan Beach, CA 90266-8567**

PHARMACY BENEFIT ADMINISTRATOR	
• **Questions about Prescriptions, Specialty Drugs, and pre-authorization of certain prescription drugs, contact Express Scripts**	**800-349-3780** **or visit the website: www.esrx.com** **Mailing address:** **Express Scripts** **4700 Nathon Lane North** **Plymouth, MN 55442-2599**

Please visit the Plan's website at www.sheetmetalsam.org where you can obtain Plan information, forms, and other materials at no cost.

Keep the Plan Informed of Address Changes

To ensure that you receive the benefits that you are entitled to, as well as any important communications, you MUST keep the Administrative Office informed of any address changes for yourself and any eligible dependents. You must also notify the Administrative Office immediately of any change in status of family members, including births, deaths, or divorces.

To protect you and your family's rights, all such changes must be received in writing. You should also keep a copy, for your records, of any notices you send to the Administrative Office.

Foreign Language Assistance / Asistencia Lengua Extranjera
This booklet contains a summary in English of your plan rights and benefits under the Plan. If you have difficulty understanding any part of this booklet, contact the Administrative Office either in person or by telephone.

AVISO A LOS PARTICIPANTES QUE HABLAN ESPAÑOL: Si tiene alguna pregunta tocante este folleto, o requiere alguna otra información tocante a su cobertura de salud, por favor no dude en comunicarse con la Oficina Administrativa al (800) 947-4338, donde habrá varios representantes bilingües que con gusto le ayudarán.

SHEET METAL WORKERS' HEALTH PLAN OF SOUTHERN CALIFORNIA, ARIZONA AND NEVADA

111 North Sepulveda Boulevard, Suite 100
Manhattan Beach, California 90266-6861
Telephone: (800) 947-4338
Website: www.sheetmetalsam.org

Dear Retiree Health Plan Participant:

This booklet is specifically for retired participants and/or their eligible dependents who are currently enrolled in the Retiree Health Plan's Medicare Supplement Option or Fee-For-Service Comprehensive Medical option. These options were closed to new retired participant enrollments as of January 1, 2003. Participants who retired on or after January 1, 2003, may be offered various HMO or EPO coverage through the Retiree Health Plan as explained in a separate SPD/Plan Document issued by the Plan.

The Medicare Supplement option and Fee-For-Service Comprehensive Medical option described in this booklet provide medical and maintenance prescription drug coverage on a self-insured basis for those enrolled in this option.

If you have any questions about eligibility or benefits, please refer to the Quick Reference Chart at the beginning of this booklet for the contact information you should use to get the answers you are seeking.

Sincerely,

THE BOARD OF TRUSTEES

TABLE OF CONTENTS

IMPORTANT NOTE: The Retiree Health Plan options described in this document are effective July 1, 2017, except for those provisions that specifically indicate other effective dates, and replaces all other summary plan descriptions or benefit booklets and inserts to those documents previously provided to you.

RETIREE HEALTH PLAN OVERVIEW

Below is an overview of:

- **Eligibility for Coverage**
- **Summary of benefits**
- **How to file a claim**

For a more complete description of eligibility requirements and benefits, please refer to the following Chapters of this booklet (these are named in the preceding Table of Contents).

NOTE: Capitalized terms used in this SPD have a precise meaning (for example, "Retired Participant," or "Sheet Metal Industry"). To be sure you understand the meaning of capitalized terms, please refer to the Glossary which starts immediately after Chapter 7 of this booklet.

The eligibility rules that apply to the Medicare Supplement option and Fee-For-Service Comprehensive Medical option, including maintenance prescription drug coverage, are contained in Chapter 1 of this booklet.

Overview of Eligibility	
Type of Individual	**Eligibility Requirement**
Retired Participants ***Refer to Chapter 1 for details, including special provisions regarding working in Non-Covered Sheet Metal Service.***	Retired participants who, as of December 31, 2002, did not reside within any of the Plan's HMO service areas, and retired prior to January 1, 2003, were eligible to elect and pay for coverage under the Medicare Supplement option or, if not entitled to Medicare, the Fee-For-Service Comprehensive Medical option. Some exceptions apply – refer to Chapter 1.
Dependents – legal spouse ***Refer to Chapter 1 for details.***	Must have been listed on the enrollment forms and proof of dependency documentation must have been submitted when due (including upon subsequent request); dependents are generally eligible during the period that the participant to whom they are related is eligible. **Your newly acquired dependent should be properly enrolled within 31 days following the date you acquired the dependent.**
Surviving Spouses of Deceased Retired Participants ***Refer to Chapter 1 for details.*** ***Eligibility is terminated if you do not enroll in***	Surviving spouses can maintain coverage in the Medicare Supplement option. Or, if not entitled to Medicare, in the Fee-For-Service Comprehensive Medical option, if, as of the date of the Retired Participant's death, the surviving spouse was

Overview of Eligibility	
Medicare Part B when you are first entitled to enroll.	enrolled as an eligible dependent under the Medicare Supplement option of Fee-For-Service Comprehensive Medical option, provided they continue to meet the requirements for eligibility and self-pay contributions are paid when due. Upon Medicare enrollment (Parts A and B), a person's coverage is changed from the Fee-For-Service Comprehensive Medical option to the Medicare Supplement option.

MEDICARE SUPPLEMENT OPTION SUMMARY

Below is a summary of benefits under the Retiree Health Plan's Medicare Supplement option. This option is available only if you are enrolled in Medicare Part A and Part B. For a summary of benefits under the Retiree Health Plan's Fee-For-Service Comprehensive Medical option, refer to a separate insert to this booklet for your medical coverage, available free of charge from the Administrative Office.

The maintenance prescription drug coverage described in this booklet applies to those covered under either the Medicare Supplement option or Fee-For-Service Comprehensive Medical option.

YOUR OUT-OF-POCKET COSTS UNDER MEDICARE	MEDICARE SUPPLEMENT COVERAGE AMOUNT
Medicare Part A Hospital Deductible per Admission	Paid in full after a $100 deductible per person per calendar year
Medicare Part A Hospital Co-insurance	Paid in full
Medicare Part B Annual Deductible	Not paid
Skilled Nursing Facility Co-insurance	Paid in full
Any Charges for Services or Supplies Not Covered by Medicare Part A or Part B	Not paid except maintenance prescription drug coverage – refer below and to Chapter 3 for coverage
Lifetime Maximum	$500,000 per person, including any amounts paid by the Retiree Health Plan's Fee-For-Service Comprehensive Medical option

MAINTENANCE PRESCRIPTION DRUG COVERAGE **For those enrolled in either the Medicare Supplement option or Fee-For-Service Comprehensive Medical option.**	
BENEFITS	**COVERAGE AMOUNT**
Annual Deductible	None
Lifetime Maximum	None
Maintenance prescription drugs dispensed at a Participating Retail Pharmacy *(30 day supply limit)*	$10 co-payment per generic drug $20 co-payment per preferred brand name drug $35 co-payment per other brand name drug
Maintenance prescription drugs dispensed through the Participating Mail Service Pharmacy *(90 day supply limit)*	$15 co-payment per generic drug $30 co-payment per preferred brand name drug $50 co-payment per other brand name drug

Note: *Maintenance prescription drugs are prescription drugs you need to take on a daily, on-going basis for a long period of time. If you are uncertain if your prescription drug is considered a maintenance prescription drug, you should contact Express Scripts customer service at 800-349-3780.*

FILING CLAIMS

Information on how to file claims is included at the end of each of the Chapters describing individual benefits. For information on what to do if you disagree with the decision made about your claim, see "Claims Review Procedures" in Chapter 7, "Other Important Information."

CHAPTER 1 - ELIGIBILITY RULES FOR COVERAGE

The eligibility rules outlined in this booklet apply to the Medicare Supplement option and Fee-For-Service Comprehensive Medical option, including prescription drug coverage, provided by the Retiree Health Plan to retired participants meeting certain special criteria.

In this Chapter you'll find information on:

- **Who is eligible**
- **When and how to enroll in coverage**
- **Self-pay requirements**
- **Coverage effective dates and termination dates**
- **Rules concerning work after retirement**
- **Qualified medical child support orders**
- **COBRA continuation coverage**

WHO IS ELIGIBLE

Eligible Retired Participants

The Medicare Supplement option and Fee-For-Service Comprehensive Medical option are only provided to participants who:

- qualify for a Pension Benefit from the Sheet Metal Workers' Pension Plan of Southern California, Arizona and Nevada (the "Pension Plan"), and
- as of December 31, 2002, did not reside within any of the Retiree Health Plan's HMO service areas, and
- retired prior to January 1, 2003, and
- for the Medicare Supplement option, are enrolled in Medicare Part A and Part B, and
- were eligible to, and elected, the Medicare Supplement option or Fee-For-Service Comprehensive Medical option on a timely basis.

Retired participants that fall in one or more of the following categories are **NOT** eligible to participate in any of the Retiree Health Plan benefit options:

- A person who worked in two calendar quarters in the geographical jurisdiction of the Plan or a related plan, in Non-Covered Sheet Metal Service after February 1, 1986, either before or after retirement, is not eligible for Retiree Health Plan coverage unless that person returns to employment for a Contributing Employer for at least as long a period of time as that person worked in Non-Covered Sheet Metal Service. However, if such person again works in Non-Covered Sheet Metal Service in any two calendar quarters, he will not again be eligible for Retiree Health Plan coverage.

- A person receiving a Pro Rata Pension from the Pension Plan and whose last pension credits were not under the Pension Plan, is not eligible for Retiree Health Plan coverage.

  (A Pro Rata Pension is provided for Pension Plan participants who would not otherwise qualify for a pension, or whose pensions would be less than the full amount, because their years of employment were divided between the jurisdiction of the Pension Plan and a "related" pension plan. Pension credits are years of service earned by Participants and used to determine eligibility for pension benefits. These terms are more fully defined in the Pension Plan SPD.)

- A person whose Pension Benefit is suspended by the Pension Plan is not eligible for Retiree Health Plan coverage during the period of suspension.

- A person receiving a Pension Benefit but who is working in suspendable sheet metal industry employment under the terms of the Pension Plan is not eligible for Retiree Health Plan coverage during the period of such work.

A retired participant, who works in suspendable employment after retirement, including covered employment, may thereafter be considered a new retiree under Pension Plan rules. In that case, he or she must meet the requirement of having at least 15 pension credits in order to qualify for enrollment in the Retiree Health Plan, and his or her self-pay contribution rate will be based on the rates applicable to the status of a new retiree. In such a case, only the Retiree Health Plan's HMO/EPO options may be available depending on the retired participant's address. The Medicare Supplement option and Fee-For-Service Comprehensive Medical option are **NOT** available to the retired participant.

Eligible Dependents

Retired participants who enrolled in the Medicare Supplement option or Fee-For-Service Comprehensive Medical option were given the opportunity to enroll their dependents if such dependents were eligible dependents as described below, and all the required documentation of dependent status was filed with the Administrative Office in a timely manner.

Eligible dependents include the participant's legal spouse (former spouses are not eligible after the effective date of the final divorce decree). Under very limited circumstances, a totally disabled child may be covered. Contact the Administrative Office for details on coverage for totally disabled children.

In no event will a spouse be covered simultaneously as a dependent and as a retired participant under the Retiree Health Plan or any coverage provided by the Plan.

You must IMMEDIATELY notify the Administrative Office in writing when changes in dependency status occur. This includes final dissolution of marriage, annulment, or death, or any other event that would make a dependent not eligible for further coverage.

Any claims paid on behalf of retired participants and/or their dependents during any period of ineligibility must be repaid to the Plan by the participant and/or the dependent including

attorney's fees, interest and reasonable collection costs. The Plan may recover these amounts through legal action or otherwise as determined in the sole and absolute discretion of the Board of Trustees or a duly authorized committee of the Board of Trustees.

Special Provision for Surviving Spouses

There are two types of coverage extensions for surviving spouses as described below.

When death occurred prior to enrollment in the Retiree Health Plan

Surviving spouses of deceased sheet metal workers were entitled to enroll in the Medicare Supplement option or Fee-For-Service Comprehensive Medical option if the following conditions were met:

- as of the date of the sheet metal worker's death, his surviving spouse was entitled to a pre-retirement survivor annuity or pre-retirement death benefits from the Pension Plan (as defined in the Pension Plan), and
- as of the date of the sheet metal worker's death, he was covered under a health plan provided by the Plan, and
- as of December 31, 2002, the surviving spouse did not reside within any of the Plan's HMO service areas, and
- the surviving spouse's enrollment in the Retiree Health plan took place prior to January 1, 2003, and
- for the Medicare Supplement option, the surviving spouse was enrolled in Medicare Part A and Part B, and
- the surviving spouse has not remarried.

Please note that the Plan's provisions regarding work in Non-Covered Sheet Metal Service as explained on page 10 also apply to this special surviving spouse provision. The work histories of both the surviving spouse and the deceased sheet metal worker are reviewed individually when determining if the surviving spouse is eligible to enroll.

When death occurs while enrolled in the Retiree Health Plan

If a retired sheet metal worker dies while he is a retired participant and covered under the Retiree Health Plan's Medicare Supplement option or Fee-For-Service Comprehensive Medical option, his surviving spouse (and eligible dependent children, if any) who is/are covered under the Retiree Health Plan as of the date of death, may continue coverage by making the required self-payments as discussed later in this Chapter.

WHEN AND HOW TO ENROLL IN COVERAGE

Retired participants were given the opportunity to enroll at the time they applied for Pension

Benefits. The Administrative Office provided you with the necessary paperwork and a description of your health care options. If you did not enroll yourself and your eligible dependents when you applied for your Pension Benefits, you are not permitted to enroll at a later date except as provided under Special Enrollment later in this Chapter.

Surviving Spouses who meet the criteria for coverage as described under Special Provision for Surviving Spouses must enroll by the date Pension Benefits become payable to the surviving spouse or by the first day of the month following the date of the retiree's death, whichever is later. If no Pension Benefits are payable to the surviving spouse, enrollment must occur by the first day of the month following the date of the retiree's death.

Adding New Dependents

Newly acquired eligible dependents (refer to page 5 for a description of eligible dependents) must be enrolled within 31 days from the date dependency status is met. If they are not enrolled by that date, you will not be permitted to enroll them at a later date.

In order to add new dependents to your coverage, certain documents must be provided to the Administrative Office along with the appropriate enrollment form. Contact the Administrative Office for the necessary form and details on what documentation must be submitted.

SELF-PAY CONTRIBUTION REQUIREMENT

Retired participants and surviving spouses must contribute towards the cost of their health care coverage under the Retiree Health Plan. The monthly self-pay contribution rates are determined and periodically changed (usually annually) by the Board of Trustees in its sole and absolute discretion. If you want to know the amounts of the current monthly self-pay contribution rates, contact the Administrative Office.

With your authorization, the self-pay contribution will be deducted from your monthly Pension Benefit. However, if the self-pay contribution is more than your monthly Pension Benefit, no deduction will be made. Instead, you must submit the entire self-pay contribution by check or money order each month to the Administrative Office.

Self-pay contributions are due by the 20th day of the month preceding each coverage month. If a self-pay contribution is not received by the Administrative Office by the due date (or if your check is returned because of insufficient funds), your coverage, including any dependent coverage, will automatically terminate with no notice from the Plan. **ONCE TERMINATED UNDER THESE CIRCUMSTANCES, COVERAGE CANNOT BE REINSTATED NOR CAN YOU RE-ENROLL IN THE RETIREE HEALTH PLAN. THE ADMINISTRATIVE OFFICE WILL NOT SEND MONTHLY BILLS OR WARNING NOTICES. IT IS THE RESPONSIBILITY OF THOSE WHO ARE REQUIRED TO SUBMIT SELF-PAY CONTRIBUTIONS TO SUBMIT THEM WHEN DUE.** You may pay several months' self-payments in advance if you wish to.

COVERAGE EFFECTIVE DATE

A retired participant who enrolled under the Medicare Supplement option or Fee-For-Service

Comprehensive Medical option at the time of his application for Pension Benefits became covered under his selected health care option on the later of the following dates, provided all enrollment and self-pay contribution requirements were met:

- the date his Pension Benefits commenced,
- the date his active eligibility under the Plan terminated, or
- the date his eligibility under the Arizona Sheet Metal Workers' Health Plan terminated.

A surviving spouse who enrolls under the Medicare Supplement option or Fee-For-Service Comprehensive Medical option when first entitled to do so as outlined under Special Provision for Surviving Spouses, will become covered under his or her selected health care option on the later of the following dates that are applicable, provided all enrollment and self-pay contribution requirements are met:

- the first day of the month following the date of her spouse's death,
- the date Pension Benefits become payable to her,
- the date her eligibility under the Plan's active Plan A or Plan B terminated, or
- the date her eligibility under the Arizona Sheet Metal Workers' Health Plan terminated.

If you are enrolling under any of the conditions specified under Special Enrollment, refer to that provision for the date your coverage becomes effective.

If dependent coverage was elected and the dependent qualified and was listed on the enrollment form, such dependent became covered on the date coverage was effective for the retired participant, provided all requested documentation was submitted on a timely basis and the required self-pay contribution is made for the dependent.

For newly acquired dependents and dependents enrolled under the Special Enrollment provision, coverage will begin on:

- the first day of the month following the date dependency status is met if an enrollment form adding the dependent is submitted to the Administrative Office within 31 days following the date dependency status is met, or
- for those enrolling under the Special Enrollment provision, on the applicable date set forth in that provision.

COVERAGE TERMINATION DATE

Coverage for a retired participant or surviving spouse enrolled in the Retiree Health Plan will terminate as of whichever of the following dates occur first:

- the first day of the month in which eligibility for Pension Benefits terminates or is suspended, or is suspendable for any reason (including for work in Non-Covered Sheet Metal Service or

in the Sheet Metal Industry),

- the first day of the month following 60 days from the date the Administrative Office receives a written request from the retired participant or surviving spouse to terminate coverage. If the retired participant or surviving spouse does not have the required self-pay contribution deducted from the monthly Pension Benefit (instead, payment is submitted to the Administrative Office by check or money order), coverage is automatically terminated as of the first day of a month if the required self-pay contribution is not received by the Administrative Office by the 20th day of the preceding month,

- the first day of the month following the date the retired participant or surviving spouse no longer resides outside any of the Retiree Health Plan's HMO or EPO service areas; in such a case, the retired participant or surviving spouse may enroll in whichever of the Retiree Health Plan's HMOs or EPO is available to him or her; enrollment must occur within 31 days following the date coverage would otherwise terminate,

- for those enrolled in the Medicare Supplement option, the date such individual is no longer enrolled in Medicare Part A and Part B,

- for those enrolled in the Medicare Supplement option, the date the retired participant or surviving spouse assigns his or her Medicare benefits to an HMO or other type of medical benefits provider,

- the date the retired participant or surviving spouse would be initially covered by Medicare Part A and Part B if such individual enrolled when first eligible but fails to enroll,

- the date the Retiree Health Plan is terminated by the Board of Trustees,

- the date the eligibility rules are modified by the Board of Trustees to exclude a class of retired participants or surviving spouses in which the retired participant or surviving spouse belong,

- the date of entrance into full-time military service with the Armed Forces of the United States, or

- with respect to a surviving spouse, the first day of the month following the date the surviving spouse remarries.

A dependent's coverage will terminate as of whichever of the following dates occur first:

- the date the retired participant's coverage terminates for reasons other than the death of the retired participant. In the event of the death of the retired participant, dependents may continue coverage in accordance with the Special Provision for Surviving Spouses (page 6),

- the first day of the month following the date the dependent no longer meets the Retiree Health Plan eligibility requirements for dependents,

- for those enrolled in the Medicare Supplement option, the date such individual is no longer enrolled in Medicare Part A and Part B,

- for those enrolled in the Medicare Supplement option, the date the dependent assigns his or her Medicare benefits to an HMO or other type of medical benefits provider,

- the date the dependent would be initially covered by Medicare Part A and Part B if such individual enrolled when first eligible but fails to enroll,

- the date the Retiree Health Plan is terminated by the Board of Trustees,

- the date the eligibility rules are modified by the Board of Trustees to exclude a class of dependents in which the dependent belongs,

- the date of entrance into full-time military service with the Armed Forces of the United States, or

- the first day of the month following the date the dependent worked two calendar quarters in Non-Covered Sheet Metal Service.

COBRA coverage may be available to dependents or former dependents upon loss of eligibility, as explained in the COBRA section. Please note that a lapse of health coverage lasting 3 consecutive months may cause you to owe an individual shared responsibility payment pursuant to the Affordable Care Act. The individual shared responsibility payment is due when you file your individual tax return.

You may avoid having to pay the individual shared responsibility payment by becoming covered under another health plan that qualifies as minimum essential coverage. Examples of minimum essential coverage include Retiree Health Plan COBRA coverage, Medicare coverage, or a plan available through the Affordable Care Act Marketplace or Exchange in your area.

More information about the individual shared responsibility provision can be found at the following IRS webpages:

- **"Questions and Answers on the Individual Shared Responsibility Provision" http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision**

- **"Individual Shared Responsibility Provision – Calculating the Payment" http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Calculating-the-Payment**

WORK AFTER RETIREMENT

At age 65 (or at age 55 if a retiree is working in pre-approved employment under the "55/25 Rule") a retired participant may work in otherwise suspendable Sheet Metal Industry employment under rules set forth in the plan booklet for the Sheet Metal Workers' Pension Plan of Southern California, Arizona and Nevada ("Pension Plan") for up to 40 hours per month and continue eligibility under the Retiree Health Plan as well as continue to receive Pension Benefits from the Pension Plan. Such work will not be credited to the participant's hour bank for active eligibility under the Plan, and the retired participant will not be eligible for health coverage under actives Plan A or Plan B by virtue of such employment. At April 1 of the year following the

year a retired participant reaches age 70-1/2, the participant's work in the Sheet Metal Industry is unrestricted, and the retiree may establish active Plan A or Plan B coverage by virtue of such employment, unless it is work under the 55/25 Rule. If active eligibility is established, coverage under the Retiree Health Plan will terminate as of the effective date of active eligibility.

COBRA COVERAGE

Who Is Eligible

The Retiree Health Plan COBRA coverage extension is only available to dependents of retired sheet metal workers (not retired sheet metal workers) who are covered under the Retiree Health Plan as dependents and whose coverage is terminating because of divorce of the retired participant from the retired participant's spouse (the divorce is called a "qualifying event").

You are NOT eligible for COBRA coverage if you are working in Non-Covered Sheet Metal Service or if your eligibility is lost because of delinquent owner-operator status. COBRA coverage will automatically terminate as of the date you start work in Non-Covered Sheet Metal Service. Once terminated, COBRA coverage cannot be reinstated.

Notification Requirements

COBRA continuation coverage will be offered to qualified beneficiaries only after the Administrative Office has been notified that a qualifying event has occurred. The participant or dependent is responsible for giving notice to the Administrative Office as soon as possible but not later than 60 days after the date of the qualifying event or the date coverage under the Retiree Health Plan is lost as a result of the event.

Notice must be received in writing and sent to the following address:

Sheet Metal Workers' Health Plan
Eligibility Department
P.O. Box 10067
Manhattan Beach, CA 90266-8567

If the Administrative Office in Manhattan Beach is not notified in writing within 60 days, the individual whose coverage under the Retiree Health Plan is terminating will not be entitled to continue coverage under COBRA.

After the dependent is notified of the right to elect COBRA coverage, the Administrative Office must be advised, by submission of a completed COBRA enrollment form, of the desire to continue coverage within 60 days after the later of 1) the date Retiree Health Plan coverage would be lost, or 2) the date the dependent was notified of the right to elect COBRA coverage.

If the COBRA enrollment form is not properly completed and submitted to the Administrative Office within the time limit specified above, the individual whose coverage under the Retiree Health Plan is terminating will not be entitled to continue coverage under COBRA except as provided under "Special COBRA Enrollment Rights" later in this Chapter.

Type of Coverage

COBRA coverage consists of the same Retiree Health Plan medical and prescription drug benefits provided to similarly situated dependents for whom a qualifying event has not occurred.

Cost of and Payment for COBRA Coverage

COBRA participants must pay for COBRA coverage on a monthly basis. The cost of coverage is based on the Plan's costs to provide coverage to participants and eligible dependents under the Retiree Health Plan. The current self-payment rates are included in the COBRA enrollment material sent by the Administrative Office. The initial self-payment for COBRA coverage must be submitted directly to the Administrative Office within 45 days from the date the participant submitted a completed COBRA enrollment form to the Administrative Office. The initial payment must cover the number of months from the date coverage would otherwise have terminated through the month in which the initial payment is made.

If a former spouse has elected COBRA coverage, and the amount required for COBRA coverage has not been paid while the 45-day grace period for payment is still in effect and a health care provider requests confirmation of coverage, COBRA coverage will be confirmed. However, the notice to the provider will state that the cost of the COBRA coverage has not been paid and that the COBRA coverage will terminate effective as of the due date of any unpaid amount if payment of the amount due is not received by the end of the grace period.

If the initial self-payment in the proper amount is not submitted to the Administrative Office within the 45-day period described above, the election of COBRA continuation coverage shall be automatically revoked and considered void and the dependent whose coverage under the Retiree Health Plan is terminating will not be entitled to continue coverage under this COBRA extension.

Subsequent self-payments must be made monthly to continue coverage. Monthly payments should be mailed by the 20th day of the month preceding each coverage month to avoid possible delays in claim payments and eligibility problems. Failure to make a monthly payment within 30 days following the beginning of the coverage month will result in termination of coverage as of the end of the period for which payment has been made. Once terminated, COBRA coverage cannot be reinstated.

The Administrative Office will not send monthly bills or warning notices. It is your responsibility to submit payments when due.

Continuation Period for COBRA Coverage

For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date coverage under the Retiree Health Plan would otherwise have ended and will be extended for a maximum of 36 months.

Termination of COBRA Coverage

Once COBRA coverage has been elected, it may be cut short (terminated) on the occurrence of any of the following events:

- termination of the Retiree Health Plan,
- failure to pay the required premium in full and on a timely basis,
- you become covered, after your COBRA election date, under another group health plan,
- you become enrolled in Medicare after your COBRA election date,
- you work in Non-Covered Sheet Metal Service.

Newly Acquired Dependents

If a COBRA beneficiary (as that term is defined by law) gets married while enrolled in COBRA coverage, the new spouse can be enrolled under the COBRA beneficiary's coverage option upon the proper submission of documentation and payment of the applicable self-payment rate within 31 days from the date dependency status was met.

Loss of Other Group Health Plan Coverage or Other Health Insurance Coverage

If, while a COBRA beneficiary is enrolled in COBRA coverage, the beneficiary's spouse loses coverage under another group health plan, the COBRA beneficiary may enroll the spouse in COBRA coverage for the balance of the extension period. The spouse must have been eligible but not enrolled in COBRA because of other coverage under a group health plan or other health insurance.

The COBRA beneficiary must enroll the spouse within 31 days after the termination of the other coverage. Adding a spouse may increase the cost for COBRA coverage.

The loss of other coverage must be due to: (a) exhaustion of COBRA coverage under the other plan, (b) termination as a result of loss of eligibility, (c) termination of the employer's contribution toward the other coverage, or (d) moving out of an HMO service area if HMO coverage terminated for that reason. Loss of eligibility does not include a loss due to failure of the individual to pay premiums on a timely basis or termination for cause.

Other Events

If, while a COBRA beneficiary is enrolled in COBRA continuation coverage under the Retiree Health Plan, his or her eligible dependent who is not enrolled in COBRA coverage under the Retiree Health Plan loses coverage through Medicaid or becomes eligible for a premium assistance program through Medicaid, the COBRA beneficiary may enroll the eligible dependent for COBRA coverage under the Retiree Health Plan for the balance of the period of COBRA continuation coverage. The spouse must have been eligible for COBRA coverage as of the date of the initial Qualifying Event, but have not enrolled.

The COBRA beneficiary must enroll the spouse *within 60 days* after the date Medicaid or CHIP

coverage is lost or the date the spouse is determined to be eligible for premium assistance.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Administrative Office 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 Administrative Office.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Eligibility Department of the Administrative Office or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

CHAPTER 2 – MEDICAL COVERAGE

The benefit descriptions in this Chapter apply to participants and eligible dependents enrolled in the Retiree Health Plan's Medicare Supplement option.

If you are enrolled in the Retiree Health Plan's Fee-For-Service Comprehensive Medical option, you should refer to the claims filing procedures in this Chapter, and a separate benefit summary insert to this booklet for your medical coverage, which is available free of charge from the Administrative Office.

In this Chapter you'll find information on the Medicare Supplement:

- **Hospital deductible**
- **Benefits for covered services**
- **Limitations and exclusions**
- **Claims filing procedures (applicable to both the Medicare Supplement option and Fee-For-Service Comprehensive Medical option)**

MEDICARE SUPPLEMENT OPTION

The Medicare Supplement option is designed to supplement the benefits provided to you by Medicare Part A (hospital/facility) and Part B (physicians/other health professionals). **Coverage is provided only for services and supplies covered by Medicare.**

Under this option, you have the choice of any provider recognized by Medicare. However, if you use a provider who does not accept Medicare's assignment, no coverage is provided for any charges that exceed Medicare's allowable limits. You would be responsible for the payment of all charges in excess of Medicare's allowable limits.

For Example: You go to a physician who does not accept Medicare's assignment. He charges you $100 for the visit. Medicare's allowable limit for providers who accept assignment is $75 for the visit. Assuming your Medicare Part B deductible has been met. Medicare pays 80% of the $75 – which is $60. This Medicare Supplement option will pay the remaining $15 of the allowable limit ($75 - $60 = $15). You are responsible for paying the entire $25 which exceeds Medicare's allowable limit ($100 - $75 = $25).

HOSPITAL DEDUCTIBLE

Before hospital benefits become available, you must satisfy the Hospital Deductible. The Hospital Deductible is $100 each calendar year. The Hospital Deductible applies separately to each family member covered by this Medicare Supplement option. The Hospital Deductible is taken from your out-of-pocket Hospital Allowable Charges that are not reimbursable by Medicare. However, the charges must be for services or supplies that are covered by Medicare (i.e. Covered Services).

The Hospital Deductible is satisfied once you have submitted out-of-pocket Hospital Allowable

Charges for Covered Services equal to the Hospital Deductible amount.

If you have not met your Hospital Deductible by October 1 of any calendar year and incur out-of-pocket Hospital Allowable Charges in October, November or December of that same year, those charges will apply to that year's Hospital Deductible and will also apply to next year's Hospital Deductible.

LIFETIME MAXIMUM

All benefits provided by the Retiree Health Plan's Medicare Supplement option and Fee-For-Service Comprehensive Medical option, except maintenance prescription drug coverage, are limited to a combined overall maximum of $500,000 per person. This overall lifetime maximum applies to each person whether or not there has been an interruption in coverage, change in retiree eligibility status or change in retiree benefit plans.

In no event will the benefits under the Medicare Supplement option and Fee-For-Service Comprehensive Medical option exceed, on a cumulative and combined basis, $500,000 in a retired participant's or dependent's lifetime, excluding any benefits paid under the maintenance prescription drug coverage described in this booklet.

BENEFITS FOR COVERED SERVICES

Medicare Part A Hospital Deductible: After the $100 Hospital Deductible has been satisfied, the Medicare Part A hospital deductible per admission that you incur will be paid in full.

Medicare Part A Co-Insurance: After the $100 Hospital Deductible has been satisfied, the Medicare Part A daily hospital member co-insurance amount you incur from the 61st through the 90th day of hospital confinement that you incur will be paid in full. The Medicare Supplement option will also pay, in full, the Medicare Part A daily hospital member co-insurance amount you incur for each of the 60 lifetime hospital reserve days you use.

Medicare Part B Co-Insurance: After Medicare's annual deductible for Part B benefits has been satisfied, the Medicare Part B member co-insurance amount of Allowable Charges you incur for Covered Services will be paid in full. Note that the Medicare Supplement option does NOT reimburse you for Medicare's Part B annual deductible.

Covered Services under Medicare Part B –

Covered Services under Medicare Part B include, but are not limited to, the following items:

- Home health services;
- Outpatient rehabilitation facility services;
- Outpatient ambulatory surgical services;
- Diagnostic x-ray tests;

- Preventive and screening services;
- X-ray, radium and radioactive isotope therapy;
- Surgical dressings;
- Casts, splints, braces and other medical devices;
- Durable medical equipment;
- Prosthetic devices;
- Ambulance services;
- Artificial limbs and eyes;
- Certain vaccines.

Skilled Nursing Facility: Medicare's daily skilled nursing facility member co-insurance amount that you incur from the 21st through the 100th day of confinement will be paid in full.

You should contact your nearest Social Security Office to obtain a complete description of covered services under Medicare or visit www.medicare.gov.

EXCLUSIONS

In addition to the General Limitations and Exclusions in Chapter 6, the Medicare Supplement option benefits are not payable for:

- services or supplies that are not Covered Services (as defined in the Glossary);
- charges that exceed Allowable Charges (as defined in the Glossary);
- services received from a practitioner that is not recognized as an eligible provider by Medicare;
- Medicare's Part B deductible for the first three pints of blood furnished on an outpatient basis during a calendar year;
- services or supplies which exceed Medicare's limits such as more than 100 days of inpatient skilled nursing facility confinement;
- services that require precertification or a second surgical opinion by Medicare if the required precertification or second surgical opinion is not obtained and such requirement is not waived by Medicare;
- Medicare's Part B annual deductible.

HOW TO FILE A CLAIM (Applicable to the Medicare Supplement option and Fee-For-Service Comprehensive Medical option)

If you are covered by the Medicare Supplement option, hospital and medical expenses should be submitted to Medicare first. After you receive Medicare's "Explanation of Benefits," send a copy of it to the Administrative Office along with a completed claim form and a copy of the original bill.

For Hospital Benefits: At the time of pre-admission testing or hospital admission, a hospital admissions office will contact the Administrative Office to verify your eligibility and hospital benefits. You should submit a completed claim form to the hospital admissions office. In most cases, the hospital will submit your claim for you. If the hospital notifies you that they do not bill your insurance, you will be responsible to submit the itemized bill to the Administrative Office.

For Medical Benefits: You or your health care provider must submit a completed claim form to the Administrative Office. The claim form must include the patient's name, the participant's name, current address, and the participant's Social Security number. Without this information the claim will be delayed until proper identification is made and if the claim remains unidentifiable, no reimbursement will be made.

Filing a Hospital or Medical Claim: A separate claim form must be submitted for each family member for whom charges are submitted. Attach to each completed form a copy of the itemized billing for that particular family member and a copy of Medicare's Explanation of Benefits if you are covered by the Medicare Supplement option. It is not necessary to complete a separate form when you are submitting multiple bills for the same family member. The itemized bills must show the provider's name, address, and tax identification number, the service that was rendered and the service date. Balance Due statements are not accepted as itemized bills.

The claim must be submitted to Administrative Office within 90 days from the date of service. If for some reason you cannot submit your claims within the 90-day period, benefits may be allowed if the charges are submitted within two years from the date of service with an explanation for the late submission of the claim. Benefits will not be allowed if the claim is submitted beyond two years from the date the expense was incurred. The incurred date of an expense is the date the service or supply is rendered or obtained by the patient.

Where to Obtain Claim Forms

You may obtain claim forms from the Administrative Office or by visiting the Plan's website at www.sheetmetalsam.org.

Where to File a Claim

Sheet Metal Workers' Health Plan of Southern California, Arizona and Nevada
Attention: Claims Department

P.O. Box 10067
Manhattan Beach, CA 90266-8567

Note: Remember, you must submit your claim to Medicare first if you are covered by the Medicare Supplement option.

Benefit Assignment

Who receives the benefit payments is determined from the claim form you submit. The front of the claim form requests your signature as authorization to release medical information. It is important that you sign this portion of the claim form. The back of the form should be signed only if you want to have the benefit payment sent directly to the provider of service. If the provider indicates on the form "assignment or signature on file," the Administrative Office will send the benefit payment to the provider. If you are covered under the Fee-For-Service Comprehensive Medical option, and services are rendered by a PPO Provider, the Administrative Office will always send the benefit payment to the PPO Provider.

Medical Payment Estimates

If you are covered by the Fee-For-Service Comprehensive Medical option, you may want to receive an estimate of benefits payable for a particular service, such as surgery. In order to receive an estimate of available benefits, the Physician must submit a written request, which includes the diagnosis codes, procedure number (i.e., CPT or CRVS) the Physician anticipates performing, and the Physician's charge for the service. If the Administrative Office receives the necessary information, the Physician will receive a written response giving the dollar amount of the Physician's charge which may be allowed and at what percentage rate or flat amount the benefits would be payable. A copy will be sent to you.

Using an Authorized Representative

An authorized representative, such as your spouse, may complete a claim submission for you if you are unable to complete it yourself and have previously designated the individual to act on your behalf. A form can be obtained from the Administrative Office to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on your behalf.

CHAPTER 3 – OUTPATIENT MAINTENANCE PRESCRIPTION DRUG BENEFITS UNDER THE MEDICARE SUPPLEMENT OPTION AND FEE-FOR-SERVICE COMPREHENSIVE MEDICAL OPTION

The provisions and benefit descriptions in this Chapter apply to participants and eligible dependents enrolled in either the Retiree Health Plan's Medicare Supplement option or the Fee-For-Service Comprehensive Medical option.

In this Chapter you'll find:

- **Benefits**
- **Descriptions of preferred drugs and maintenance drugs**
- **Prescription quantity**
- **Covered drugs**
- **Exclusions**
- **How to use the retail program**
- **How to use the mail service program**
- **Information on specialty medications**
- **How to reach the prescription drug administrator**

The Prescription Drug Benefits are part of the Medicare Supplement option and Fee-For-Service Comprehensive Medical option. However, the benefits are not subject to any medical deductible or lifetime maximum benefit. The Prescription Drug Plan has its own co-payments, and benefit provisions as described below.

BENEFITS

If you obtain your covered outpatient maintenance prescription drugs at a Participating Pharmacy and in accordance with the procedures outlined on the following pages, the only cost to you will be the co-payment outlined below. The Plan will pay the balance of the prescription cost. Your Prescription Drug I.D. card shows Participating Pharmacies near your home. If you need to know the location of other Participating Pharmacies, call Express Scripts at (800) 349-3780 or visit www.esrx.com.

Location	Copayment You Pay For Each Prescription Filled Or Refilled	Type of Drug
Participating Retail Pharmacy Location	$10	Generic drug
	$20	Preferred brand name drug
	$35	Non-preferred brand name drug
Mail Order (Home Delivery) Service	$15	Generic drug
	$30	Preferred brand name drug
	$50	Non-preferred brand name drug
Specialty Pharmacy (Accredo)	$10	Specialty drug

WHAT IS A PREFERRED DRUG?

A preferred drug is a brand-name medication included on your prescription drug benefit's formulary. A formulary is a list of medications preferred by Express Scripts because they are safe and effective and help to control costs. These savings may affect you either directly (for example, through lower co-payments) or indirectly (for example, the Plan pays less for the medication, which helps keep your benefit more affordable).

WHAT IS A MAINTENANCE DRUG?

Maintenance prescription drugs are drugs which can only be lawfully dispensed with the written or oral prescription of a physician and which are classified as maintenance drugs by First Data Bank or similar organization used by Express Scripts for the pricing and categorization of prescription drugs. In general, they are medications that you need to take on a daily basis for a long period of time. If you are uncertain if your prescription drug is considered a maintenance drug, you should contact Express Scripts customer service at (800) 349-3780.

PRESCRIPTION QUANTITY

Up to a 30-day supply is allowable at retail Participating Pharmacies, providing your Physician prescribed that amount.

A minimum 30-day supply and a maximum 90-day supply is allowable under the mail service program, providing your Physician prescribed that amount.

COVERED DRUGS

- All maintenance drugs, which under federal or California law, require the written or oral prescription of a licensed Physician, except those listed under "Exclusions."

- Insulin and diabetic supplies, including insulin syringe, needles, test tablets, lancets and tape designed to test for sugar, and acetone strips for measuring blood sugar, if prescribed by a Physician.

EXCLUSIONS

In addition to the General Limitations and Exclusions listed in Chapter 7, Maintenance Prescription Drug benefits are not payable for:

- drugs or medicines not requiring a Physician's prescription, except items listed under Covered Drugs when prescribed by a Physician;
- blood and blood plasma, immunization agents, or biological sera;
- drugs for hair removal or replacement, such as Rogaine or Vaniga;
- maintenance drugs that are not dispensed at or through a Participating Pharmacy;
- drugs in connection with smoking secession;
- Retin-A except for treatment of acne vulgaris;
- over-the-counter vitamins (except as required by federal law), cosmetics, dietary supplements, health and beauty aids;
- weight control medication;
- drugs or medications in connection with the treatment of infertility;
- non-drug items such as therapeutic devices or appliances, surgical garments, and surgical dressings; and
- drugs not yet approved by the FDA. New FDA-approved drugs are covered unless the class of drug is excluded.

HOW TO USE THE RETAIL PROGRAM (30-day supply maximum)

Go to a Participating Pharmacy. Several pharmacies are listed on your Prescription Drug I.D. card. If you need other locations, call Express Scripts at (800) 349-3780 or visit www.esrx.com. Present your prescription and Prescription Drug I.D. card to the pharmacist.

When you receive your prescription, pay your co-payment amount for each prescription and sign the pharmacy's register acknowledging you received the prescription(s).

HOW TO USE THE MAIL SERVICE (HOME DELIVERY) PROGRAM (90-day supply maximum)

Maintenance drugs should be dispensed through the mail service pharmacy. First Class U.S. Mail or a national mail courier service like UPS delivers your prescription drugs directly to your home.

Points of Home Delivery

- **Web Registration: After registering on www.esrx.com, a member can perform the following tasks on the website (this list is not all-inclusive.)**
  - Refill and renew prescriptions
  - Request a prescription transfer from retail to home delivery
  - Check order status
  - Locate a participating retail pharmacy (PPO Lookup)
  - Review prescription history

- **Physicians can submit new prescriptions by:**
  - ePrescribing
  - Easy Rx Faxing for prescriber only (Fax# 800.837.0959)
  - Call in a prescription for prescriber only (Phone # 888.327.9791, Prompt #2)

- **Patients can mail new Rx's to**:
  Express Scripts
  P.O. Box 66568
  St. Louis, MO 63166-6568

Payment Options: Your co-payment can be paid by check or credit card (VISA, MasterCard, Discover or American Express). If paying by credit card, the prescription drug plan administrator will keep your signature on file (taken from the "payment" section of the Mail Order Patient Profile) and will automatically place future charges on your credit card. To cancel your authorization, please notify the prescription drug plan administrator in writing.

Account balances of $150 or more, which remain unpaid for 150 days or more, will be marked overdue, and will affect future refill requests.

SPECIALTY MEDICATIONS

Specialty medications treat chronic complex conditions such as Rheumatoid Arthritis, Cancer, Multiple Sclerosis, Hepatitis C, Crohn's Disease, Bleeding Disorders, Asthma, Psoriasis, and more. These drugs come in many forms and may be taken orally, injected with a syringe and needle, or inhaled with a nebulizer. People taking these medications require a higher level of support than traditional medications.

Express Scripts' specialty pharmacy, Accredo, can provide these specialty medications and technical care.

To receive your next supply of specialty medication, please call Accredo toll-free at (800) 803-2523 and a patient care coordinator will contact your doctor to get your prescription and work with you to schedule a delivery time for your medication.

Your specialty medication can be delivered to your home, your doctor's office, or any approved location. All needed supplies, such as needles, syringes, and alcohol wipes are included at no additional cost to you. You will also have access to other services available only through Accredo, including:

- Access to experienced specialty healthcare experts 24/7
- Guidance in how to take specialty medications correctly
- Support in managing your medical condition
- Personal care and health advocacy through an Accredo patient care coordinator.

HOW TO REACH THE PRESCRIPTION DRUG BENEFIT ADMINISTRATOR

Express Scripts has a toll-free number, (800) 349-3780. If you have any questions on the network pharmacy or mail service program, need a new or additional I.D. card, or need to find a Participating Pharmacy, call (800) 349-3780.

CHAPTER 4 - COORDINATION OF BENEFITS (COB)

The Coordination of Benefits provision described in this Chapter applies to the Fee-For-Service Comprehensive Medical option. It also applies to the Medicare Supplement option but only if you are covered by another group plan in addition to being covered by Medicare and the Medicare Supplement option.

In this Chapter you'll find:

- **Carve-out COB method**
- **Rules for determining primary plan**
- **How to file claims when you are covered under more than one plan**
- **Facility of payment**

For purposes of this Coordination of Benefits (COB) provision, "group plan" means (1) group, blanket or franchise insurance, (2) service plan contracts, group practice, individual practice and other prepayment coverage, or (3) labor-management trustee plans, union welfare plans or employee benefit organization plans; and "Plan" means the Fee-For-Service Comprehensive Medical option or the Medicare Supplement option under the Retiree Health Plan

Note: The Medicare Supplement option does not coordinate benefits with Medicare. The benefits under the Medicare Supplement option are provided on a supplemental basis only. Medicare is always primary (pays first) to the Retiree Health Plan's Medicare Supplement option.

CARVE-OUT COB METHOD

The Plan uses a carve-out COB method. Specifically, after any Plan deductible is met, the Plan will pay either its regular benefits or, if another group plan is primary to the Plan, a reduced amount which, when added to the benefits payable by the other plan(s) will equal no more than what the Plan would have paid if it were primary. When determining the medical benefits payable under the Plan if it were primary, the Plan will use the PPO level of benefits even if a PPO provider is not used.

Benefits payable by the other group plan include benefits that would have been payable had claim been duly made for them or, in the case of an HMO or other managed health care plan, the benefits that would have been available had the individual followed the plan's coverage rules for obtaining covered services. In the event an individual does not follow his other plan's rules for obtaining covered services and such plan is primary to the Plan in accordance with the "Rules for Determining Primary Plan" that begin on page 27, then the Plan will not pay more than the member co-payments or co-insurance that would have applied under the other plan for the services rendered had the individual followed the other plan's coverage rules.

Example: *A spouse is covered by the Fee-For-Service Comprehensive Medical option. The spouse also has HMO coverage through his or her employer. That employer's plan is therefore primary for your spouse. If your spouse decides to obtain medical care from a non-HMO doctor, and the HMO plan provides no benefits when services are rendered by a non-HMO doctor, the Fee-For-Service Comprehensive Medical option will only pay the member co-payment that would have applied had the spouse received care from his or her designated HMO doctor. You will be responsible for the balance of charges.*

Under no circumstances will the Plan pay more than what the participant would be responsible for paying in the absence of Plan coverage.

Following is an example of how benefits under the Fee-For-Service Comprehensive Medical option are determined when the Plan is secondary to another group plan.

Example:

Spouse's fee-for-service plan is primary
This Plan (Fee-For-Service Comprehensive Medical option) is secondary for the Spouse
Assuming all deductibles are met –

Total charges	*$500*
Spouse's plan pays	*-350*
Balance owing	*$150*
Benefit payable under the Plan if it were primary	*$400*
Benefit payable by spouse's plan	*-350*
The Plan will pay	*$ 50*
Balance owing before the Plan's payment	*$150*
The Plan's payment	*- 50*
Balance owed by you	*$100*

Following is an example of how benefits under the Medicare Supplement option are determined when this Plan is secondary to another group plan in addition to being secondary to Medicare. In other words, you are covered by three plans – Medicare, the Retiree Health Plan's Medicare Supplement option and another group plan.

Example:

Medicare is primary
Spouse's fee-for-service plan is secondary to Medicare
This Plan (Medicare Supplement option) is secondary to the spouse's fee-for-service plan
Assuming all deductibles are met –

Total charges	*$500*
Medicare pays	*-400*
Balance owing	*$100*
Spouse's fee-for-service plan pays	*$100*
Balance owing	*$ 0*
The Plan pays	*$ 0*

Under most circumstances, the Retiree Health Plan's Medicare Supplement option will pay nothing if you are also covered by another group plan that is primary to this Plan.

RULES FOR DETERMINING PRIMARY PLAN

A. Basic Rules

The basic rules used to determine which plan is primary (pays first) are below. These rules do not apply to persons covered under a COBRA extension. Refer to the special provisions that apply to these coverages.

- A plan with no coordination of benefits provision is primary to a plan which has a coordination of benefits provision.

- A plan covering the claimant as an active employee is primary to a plan covering the claimant as a laid-off or retired employee or as a dependent.

- A plan covering the claimant as a dependent of an active employee is primary to a plan covering the claimant as a dependent of a laid-off or retired employee.

- When two plans cover the claimant as a dependent child of an active employee or when two plans cover the claimant as a dependent child of a laid-off or retired employee, the plan covering the parent whose birthday (month and day only) occurs first during a calendar year is primary to the plan covering the parent whose birthday occurs later during a calendar year, unless the parents are legally divorced.

  In cases where the parents are legally divorced, the following rules apply:

  - a plan covering the claimant as a dependent child of a parent with financial responsibility for the child's health care expenses by virtue of a court decree is primary; however, if the specific terms of a court decree state that the parents shall

share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the "birthday rule" previously outlined,

- if there is no court decree, a plan covering the claimant as a dependent child of a parent with legal custody is primary,

- if there is no court decree and the parent with legal custody has remarried, the order of benefit determination is:

  1) a plan covering the parent with legal custody,

  2) a plan covering the stepparent with legal custody, and

  3) a plan covering the parent without legal custody.

B. Special Rules for COBRA Extension

If a claimant is covered under a COBRA extension and is also covered under another plan, the plan covering the claimant on a basis other than under a COBRA extension is primary to a plan covering the person under a COBRA extension.

C. Final Determination

If none of the above rules determine which plan is primary, the plan that has covered the claimant for the longer period is primary to the plan covering the claimant for the shorter period. The claimant's length of time covered under a plan is measured from the claimant's first date of coverage under the plan (whether or not there has been an interruption of coverage).

FILING CLAIMS WHEN YOU ARE COVERED UNDER MORE THAN ONE PLAN

First, you need to determine which plan is primary for your claims based on the preceding rules. Submit your claims to the primary plan first. After you receive an "explanation of benefits" (or similar notice) from the primary plan, submit a copy of it, along with your itemized claim, to the secondary plan. If you have any questions about which plan is primary, call the Administrative Office.

FACILITY OF PAYMENT

Whenever payments which should have been made under the Plan in accordance with these provisions, have been made under any other plan, the Plan has the right in its sole discretion to pay any organization making such payment any amounts it determines to be warranted in order to satisfy the intent of this Coordination of Benefits provision. Amounts so paid will be deemed to be benefits paid under the Plan and to the extent of such payments the Plan will be fully discharged from liability under the Plan.

CHAPTER 5 - MEDICARE AND PLAN BENEFITS

In this Chapter you'll find:

- **General information about Medicare**
- **How to enroll in Medicare**
- **Medicare assignment**
- **Medicare Part D prescription drug information**

GENERAL MEDICARE INFORMATION

Medicare benefits are available to individuals age 65 or older, individuals who have been on Social Security disability benefits continuously for two years, and individuals with end-stage renal disease (ESRD). It is important that you enroll in this extensive program of health insurance (Parts A and B) promptly upon eligibility.

YOUR COVERAGE UNDER THE RETIREE HEALTH PLAN WILL TERMINATE WHEN YOU BECOME ELIGIBLE FOR MEDICARE UNLESS YOU HAVE ENROLLED IN MEDICARE PARTS A AND PART B AND DO NOT ASSIGN YOUR MEDICARE BENEFITS TO AN HMO OR OTHER TYPE OF MEDICAL BENEFITS PROVIDER.

HOW TO ENROLL IN MEDICARE

If you are approaching age 65, you are not automatically enrolled in Medicare unless you have filed an application and established eligibility for a monthly Social Security benefit. If you have not applied for Social Security benefits, you must file a Medicare application form during the 3-month period prior to the month in which you become 65 years of age in order for coverage to begin at the start of the month in which you reach age 65. Call or write your nearest Social Security office 90 days prior to your 65th birthday and ask for an application card.

If you will become eligible for Medicare before age 65, please notify the Administrative Office prior to the date of your Medicare eligibility.

INFORMATION ABOUT THE MEDICARE PRESCRIPTION DRUG PROGRAM

Under Medicare Part D, prescription drug coverage is available to everyone with Medicare. This coverage is offered through private Medicare prescription drug plans. All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

Because you have existing prescription drug coverage that, on average, is as good as or better than Medicare's standard coverage, you can keep your prescription drug coverage provided by the Retiree Health Plan and you do NOT need to enroll in a Medicare prescription drug plan. You will not have to pay the Late Enrollment Penalty (described below) if you choose to join a Medicare prescription drug plan at a later time.

EVEN THOUGH YOU CAN ENROLL IN A MEDICARE PRESCRIPTION DRUG PLAN, IT IS LIKELY TO BE IN YOUR BEST INTEREST NOT TO ENROLL IN ANY OF THEM SO LONG AS YOU MAINTAIN YOUR COVERAGE UNDER THE RETIREE HEALTH PLAN. If you do enroll in a Medicare prescription drug plan, you will have to pay the premium for it.

What Happens if you Lose or Drop Coverage under the Retiree Health Plan

Your current coverage under the Retiree Health Plan will continue as long as the coverage remains in effect, you remain eligible for it, and the required self-pay contributions are paid on time.

If for some reason you drop or lose your coverage under the Retiree Health Plan, you can then enroll in a Medicare prescription drug plan. **If you don't enroll in a Medicare prescription drug coverage after your current coverage ends**, you may pay more to enroll in Medicare prescription drug coverage later.

Late Enrollment Penalty (also referred to as "Higher Premium Charge")

If you have a gap of 63 days or longer without creditable prescription drug coverage (creditable meaning that drug coverage is at least as good as Medicare's standard prescription drug coverage), and you decide to join a Medicare prescription drug plan, your monthly premium for that Medicare drug coverage will increase by at least 1% per month for every month after you became eligible for Medicare and did not have either Medicare drug coverage or coverage under a creditable drug plan. This is referred to as a late enrollment penalty.

- For example, if 19 months pass during which you do not have creditable prescription drug coverage, when you decide to join Medicare's drug coverage your monthly premium will always be at least 19% higher than what most other people pay. In addition, you may have to wait until the next November to enroll.

You are urged to contact the Administrative Office if you have any questions regarding your prescription drug coverage.

CHAPTER 6 – GENERAL LIMITATIONS AND EXCLUSIONS

The general limitations and exclusions listed in this Chapter apply to the Medicare Supplement option and Fee-For-Service Comprehensive Medical option, including the Maintenance Prescription Drug Benefits described in this booklet.

In this Chapter you'll find:

- **General limitations and exclusions that apply to the Medicare Supplement option and Fee-For-Service Comprehensive Medical option, including prescription drug benefits**
- **How expenses incurred outside the United States are handled.**

All of the benefits under the Medicare Supplement option and Fee-For-Service Comprehensive Medical option, including prescription drug benefits, are subject to the following limitations and exclusions in addition to those outlined under each benefit description.

No payment will be made for:

1. medical services or supplies which do not meet the definition of Covered Services or charges which exceed the definition of Allowable Charges;

2. any bodily injury or sickness for which the patient is not under the care of a provider who is determined by the Plan to be a Recognized Provider; or care or treatment provided by a Recognized Provider to the extent such care or treatment is outside the scope of the Recognized Provider's license or certification or the care or treatment is not a covered service under the Retiree Health Plan option that covers the individual;

3. conditions caused by or arising out of an act of war, armed invasion or aggression;

4. any services or supplies:

   (a) for which no charge is made, or

   (b) for which you are not required to pay in the absence of payment by the Plan, or

   (c) furnished by a hospital or facility operated by the United States government or any authorized agencies thereof or furnished at the expense of such government or agencies, except as required by federal law, or

   (d) furnished by a Hospital or facility operated by any state government or any authorized agencies thereof or furnished at the expense of such government or agencies, or

   (e) which are provided without cost by any municipal, county, or other political

subdivision.

Nothing in the foregoing exclusion shall be construed to preclude a state's right to reimbursement for benefits it has paid on behalf of a participant under the Medicaid program. The Plan will honor any subrogation rights that a state may have gained from a Medicaid-eligible beneficiary covered by the Plan by virtue of the state's having paid Medicaid benefits for which the Plan has a legal liability to cover in accordance with applicable law;

5. any condition arising out of occupational injuries or illnesses even though you fail to claim your right to such benefits or for which benefits of any nature are recovered or found to be recoverable, whether by adjudication or settlement, under any worker's compensation or occupational disease law;

6. services or supplies received by you which are provided by your spouse, child, brother, sister, or parent, or those of your spouse or provided by a person who normally lives with you;

7. any services, procedures, or supplies which are, in the sole and absolute discretion of the Board of Trustees or its delegate, considered Experimental or are not within the standards of generally accepted medical or dental practice;

8. with respect to an allowable transplant, benefits will be provided to an organ or tissue donor for Allowable Charges incurred by that person (whether or not that person is covered under the Fee-For-Service Comprehensive Medical option), which are directly related to the transplant surgery only if the organ or tissue recipient is covered under the Fee-For-Service Comprehensive Medical option, and, further, provided that such Allowable Charges are not payable by any other medical plan (individual or group) in the absence of coverage provided by the Fee-For-Service Comprehensive Medical option. Benefits for an organ or tissue donor are limited to a maximum payment of $50,000 per transplant. If the covered person is an organ or tissue donor and the organ or tissue recipient is not also covered under the Fee-For-Service Comprehensive Medical option, benefits will not be provided to the organ or tissue donor for charges directly related to the transplant surgery;

9. any treatment received while you are incarcerated in any penal institution or jail facility or jail ward of any State or political subdivision, any court-ordered care or any treatment in connection with the commission of a crime by you, except that this exclusion shall not apply to treatment of an injury resulting from an underlying health factor;

10. any benefit that would otherwise be available, if the Plan determines that payment has already been made or is likely to be made for same from a third party, for example, a personal injury lawsuit settlement that the Plan determines includes payments for future medical care;

11. care or treatment of injuries resulting from an individual's commission of, or attempt to commit, an assault or felony unless such injury is the result of domestic violence or the commission or attempted commission of an assault or felony is the direct result of an

underlying health factor;

12. fees to complete claim forms;

13. medical services, tests, or supplies performed or provided by any provider which solicits patients at public events and/or advertising that it will accept whatever payments are made by the patient's insurance company or other organization which provides payments for dental or health care, except that this exclusion shall not apply to a facility which has been approved by the Plan or the Plan's preferred provider organization; and

14. the Board of Trustees reserves the right to determine that a provider is not a Recognized Provider and that no benefits will be payable for services or supplies provided by that provider on the basis that such provider has performed unnecessary services, billed in an inappropriate manner, or has engaged in any questionable, unethical, or fraudulent billing practices as determined in the sole and absolute discretion of the Board of Trustees or its delegate.

Expenses Incurred Outside the United States and Its Territories

Applicable to the Comprehensive Medical option –

Charges for health care expenses incurred outside the United States are not covered unless they are for emergency care or for care of illness or injury incurred while outside the United States while traveling on business or vacation. Coverage is further limited to health care services or supplies that would be covered under the Fee-For-Service Comprehensive Medical option if they were rendered or obtained in the United States.

You may be responsible for the cost of medical care at the point of service while traveling outside of the United States. Should this occur, the medical record and bill for services will be required in order for the Plan to reimburse the medical claim. Please contact the Administrative Office at (800) 947-4338 if you have questions concerning your health care coverage when traveling outside of the United States.

Applicable to the Medicare Supplement option –

Benefits under the Medicare Supplement option are provided for health care expenses incurred outside the United States only when benefits are paid or applied to applicable deductibles by Medicare for such expenses.

CHAPTER 7 – OTHER IMPORTANT INFORMATION

This Chapter includes:

- **Privacy of health information**
- **Use and disclosure of protected health information**
- **Claims review procedures**
- **Third party liability**
- **Disclaimers**
- **General Plan provisions**
- **Your rights under ERISA**
- **Plan Facts**

PRIVACY OF HEALTH INFORMATION

The Plan complies with rules included in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regarding how your health information may be used and disclosed and how you can get access to it. The Plan's Privacy Notice can be viewed online at the Administrative Office's website, www.sheetmetalsam.org, and a copy is available at no charge from the Administrative Office.

It may be necessary for you to complete and submit to the Administrative Office a HIPAA authorization form if you want the Administrative Office to release information about you to someone else such as your Union representative, spouse, or adult child. Likewise, if your spouse or child 18 years of age or older wants the Administrative Office to release information about himself or herself to someone else such as you, it may be necessary for them to complete and submit a HIPAA authorization form. The authorization forms can be obtained from the Administrative Office.

HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

A federal law, HIPAA, as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires that the Plan maintain the privacy of your personally identifiable health information (called **Protected Health Information or PHI**).

- The term **"Protected Health Information" (PHI)** includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic, or any other form.
- **PHI does not include** health information contained in employment records held by an employer who participates in this Plan in its role as an employer, including but not limited to health information on disability, work-related illness/injury, sick leave, Family and Medical Leave (FMLA), death benefits, life insurance, drug testing, etc.

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy

Practices, which was previously distributed to you upon enrollment in the Plan and is also available from the Administrative Office and on the Plan's website, www.sheetmetalsam.org. Information about HIPAA in this document is not intended to and cannot be construed as the Plan's Notice of Privacy Practices.

The Plan, and the Plan Sponsor (the Board of Trustees of the Plan), will not use or further disclose information that is protected by HIPAA ("protected health information" or "PHI") except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law. **In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor**.

Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim, appeal or for other reasons related to the administration of the Plan.

A. **The Plan's Use and Disclosure of PHI:** The Plan will use protected health information (PHI), without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by the privacy regulations under the HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.

- **Treatment** is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your health care providers. The Plan rarely, if ever, uses or discloses PHI for treatment purposes.
- Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits with activities that include, but are not limited to, the following:

  a. Determination of eligibility, coverage, cost sharing amounts (e.g. cost of a benefit, Plan maximums, and copayments as determined for an individual's claim), and establishing employee contributions for coverage;

  b. Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), coordination of benefits, subrogation of health benefit claims, billing, collection activities and related health care data processing, and claims auditing; and

  c. Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization management, including precertification, concurrent review and/or retrospective review.

- **Health Care Operations** includes, but is not limited to:

  a. Business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development or improvement of methods of payment or coverage policies, quality assessment, patient safety activities;

b. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;

c. Underwriting (the Plan does not use or disclose PHI that is genetic information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), enrollment, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;

d. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

e. Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, customer service, resolution of internal grievances, or the provision of data analyses for policyholders, Plan sponsors, or other customers;

f. Compliance with and preparation of documents required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500's, Summary Annual Reports and other documents.

B. **When an Authorization Form is Needed:** Except with respect to legal spouses, the Plan will require that you sign a valid authorization form (available from the Administrative Office) in order for the Plan to use or disclose your PHI **other than** when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment, or health care operations, or other instance in which HIPAA explicitly permits the use or disclosure without authorization. The Plan will automatically disclose PHI related to treatment, payment, or health care operations to a legal spouse, unless an individual completes a valid form to revoke a personal representative, which is available from the Administrative Office.

C. **The Plan will disclose PHI to the Plan Sponsor only** upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the Plan Sponsor agrees to:

1. Not use or disclose the information other than as permitted or required by the Plan Document or as required by law;

2. Ensure that any agents, including their subcontractors, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules;

3. Not use or disclose the information for employment-related actions and decisions;

4. Not use or disclose the information in connection with any other benefit or employee benefit plan of the Plan Sponsor, (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices);

5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
6. Make PHI available to the individual in accordance with the access requirements of HIPAA;
7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
8. Make available the information required to provide an accounting of PHI disclosures;
9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of the Dept. of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA;
10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
11. If a breach of your unsecured protected health information (PHI) occurs, the Plan will notify you.

D. **In order to ensure that adequate separation between the Plan and the Plan Sponsor is maintained** in accordance with HIPAA, only the following employees or classes of employees may be given access to use and disclose PHI:
   1. The Plan's Privacy Officer and Security Officer,
   2. Staff of the Administrative Office that administer the benefits of the Plan including COBRA administration,
   3. Business Associates under contract to the Plan including but not limited to the medical claims administrator, preferred provider organization network, utilization management company, Substance abuse treatment program administrator, and outpatient prescription drug program.

E. The persons described in section D above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this obligation, the Plan Sponsor has designed a mechanism for resolution of noncompliance. **Issues of noncompliance** (including disciplinary sanctions as appropriate) will be investigated and managed by the Plan's Privacy Officer (whose contact information is listed on the Quick Reference Chart at the front of this document).

   If you are a minor and have concerns about the Plan releasing PHI to your parents or guardian, please contact the Privacy Officer.

F. Effective April 21, 2005 in compliance with **HIPAA Security** regulations, the Plan Sponsor will:
   1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,

2. Ensure that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures,
3. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and
4. Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

G. **Hybrid Entity**: For purposes of complying with the HIPAA Privacy rules, this Plan is a "hybrid entity" because it has both group health plan functions (a health care component of the entity) and non-group health plan functions (such as pension benefits). The Plan designates that its health care group health plan functions are covered by the privacy rules. The health care group health plan functions include the self-funded medical plan options with outpatient prescription drug benefits and COBRA administration.

NON-DISCRIMINATION IN HEALTH CARE

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sexual orientation, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sexual orientation, or sex.

The Plan provides free aids and services to people with disabilities to communicate effectively with the Plan, such as qualified sign language interpreters and written information in other formats such as large print, audio, and accessible electronic formats. The Plan also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Plan and/or take other available actions.

For more information, contact the Civil Rights Coordinator for the Plan at the Administrative Office, or visit the Plan's website at www.sheetmetalsam.org.

CLAIMS REVIEW PROCEDURES

These claims review procedures apply only to claims or appeals that pertain to:

- eligibility under any of the Plan's benefit options,
- the Medicare Supplement option including Prescription Drug Benefits provided to individuals covered under that option, and
- the Fee-For-Service Comprehensive Medical option including Prescription Drug Benefits provided to individuals covered under that option.

When a Claim is submitted, it is identified as a pre-service, urgent care, post-service, or concurrent care Claim.

A "pre-service" Claim is a Claim for a benefit for which the Plan requires approval before medical care is obtained. (An example would be a request for prior approval of an organ transplant.)

An "urgent care" Claim is a pre-service Claim for medical care or treatment that, if normal "pre-service" Claim standards are applied, could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. (An example of this type of Claim would be a request for prior approval of a diagnostic test for appendicitis.)

A "concurrent care" Claim is a Claim to continue a previously approved ongoing course of treatment. (Examples would be (1) a Claim to reinstate a previously approved five-day inpatient hospital stay after the Plan determined, upon review of the claim, that it was appropriate to reduce the hospital stay to three days; or (2) a Claim to extend to eight days an inpatient hospital stay originally approved for five days.)

A "post-service" Claim is a Claim for benefits that is not a "pre-service," "urgent care," or "concurrent care" Claim. (An example would be a Claim for benefits for diagnostic tests already performed.)

Timing of Initial Claims Decisions

A determination on your claim will be made within the following time frames:

An initial determination on **urgent care Claims** will be made by the Plan or its authorized designee within 72 hours from receipt of the Claim. If the Plan or its authorized designee notifies the claimant within 24 hours of receipt of the Claim that additional information is needed to make a determination on the Claim, the claimant will have 48 hours to respond. The deadline for the initial determination will then be suspended for 48 hours or until the information is received.

An initial determination on **pre-service Claims** will be made by the Plan or its authorized designee within 15 calendar days from receipt of the Claim (30 calendar days if additional information is needed and the Plan informs the claimant of the extension within 15 days from receipt of the Claim). If additional information is needed from the claimant, the claimant will have 45 days to respond. The deadline for the initial determination will then be suspended for 45 days or until the information is received. The claimant will be notified of the decision within 15 days after the additional information is received or the end of the 45-day response period whichever is earlier.

An initial determination on **post-service Claims** will be made by the Plan or its authorized designee within 30 calendar days from receipt of the Claim (45 calendar days if additional information is needed and the Plan informs the claimant of the extension within 30 days from receipt of the Claim). If additional information is needed from the claimant, the claimant will have 45 days to respond. The deadline for the initial determination will then be suspended for 45 days or until the information is received. The claimant will be notified of the decision within 15 days after the additional information is received or the end of the 45-day response period

whichever is earlier.

Regarding concurrent care claims, in the event of a decision to reduce or terminate a previously approved ongoing course of treatment, the Plan will notify the claimant early enough to allow the claimant to have an appeal of such decision decided before the benefit is reduced or terminated. If request is made to extend a course of treatment beyond the period of time or number of treatments previously approved, and the treatment does not involve urgent care, the request will be treated as a new benefit claim and decided within the time frames applicable to pre-service Claims or post-service Claims. If a request is made to extend a course of treatment that does involve urgent care, the request will be acted upon by the Plan or its authorized designee within 24 hours of receipt of the Claim, provided the Claim is received at least 24 hours prior to the expiration of the approved treatment. If the request to extend a course of treatment involving urgent care is not received at least 24 hours prior to the expiration of the approved treatment, the request will be treated as an urgent care Claim and will be processed in accordance within the time frames applicable to such Claims.

Claims are processed according to the Plan's rules. The initial determination of your Claim, made by the Plan or its authorized designee, will be provided in writing (with the exception of urgent care notifications, which may be provided orally within 72 hours and then confirmed in writing up to three days later).

Denied Claims (Adverse Benefit Determinations)

Whenever your claim is denied in whole or in part, you will be provided notice of the Adverse Benefit Determination. Notice will be either in the form of correspondence or an explanation of benefits (EOB) from the Plan or its authorized designee.

Adverse Benefit Determinations involving Urgent Claims may be provided to the claimant orally and written notification will also be furnished to the claimant not later than 3 days after the oral notification.

Written notices will include the following information:

- information sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
- a statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review;
- the specific reason(s) for the determination, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
- reference to the specific Plan provision(s) on which the determination is based;
- a description of any additional material or information necessary if you want a further review of the claim and an explanation of why the material or information is necessary;

- an explanation of the Plan's first and second level appeal and the external review process, along with any time limits and information regarding how to initiate the next level of review;

- a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse appeal determination (civil actions must be brought within one year of a final and binding decision of the Board of Trustees on your claim or appeal; see page 50);

- if an internal rule, guideline, protocol, or other similar criterion was relied upon in deciding your claim, either a copy of the rule, guideline, protocol or other similar criterion, or a statement that it was relied upon in deciding your claim and that it is available upon request at no charge;

- if the determination was based on not being Medically Necessary or the treatment's being Experimental or investigational or other similar exclusion, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge; and

- disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

For pre-service claims, you will receive notice of the determination orally or in writing even when the claim is approved. If the Adverse Benefit Determination concerns an Urgent Claim, the notice will contain a description of the expedited review process applicable to such claims.

If you do not understand English and have questions about a claim denial, contact the Administrative Office (contact information is listed on the Quick Reference Chart).

- **SPANISH (Español): Para obtener asistencia en Español, llame al 800-947-4338.**
- **TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 800-947-4338.**
- **CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 800-947-4338.**
- **NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-947-4338.**

Internal Appeal of an Adverse Benefit Determination

If your claim is denied in whole or in part or you disagree with the decision made on a claim, you may ask for a review (appeal the decision). This Plan maintains a two-level appeals process. Appeals must be submitted in writing (with the exception of urgent care appeals, which may be oral) to the Administrative Office. The Administrative Office must receive the request for review within 180 days from the date of your receipt of the answer with which you disagree. Late requests may be rejected as untimely. You may submit any additional evidence or argument to support your position.

A review will then be made by the Eligibility Committee, which is a Committee of the Board of Trustees of the Plan whose members are appointed by the Board. The Eligibility Committee will independently consider all comments, documents, records, and other information submitted by you or your authorized representative relating to the claim, without regard to whether such

information was submitted or considered in the initial benefit determination.

You will be advised in writing of the decision of the Eligibility Committee. This will include a written explanation giving detailed reasons for any denial, specific reference to the Plan provisions on which the denial is based, a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary, and a description of the Plan's review procedures and applicable time limits, including a statement of your right to bring a civil action under Section 502(a) of ERISA following completion of the Plan's two-level appeals process. (Civil actions must be brought within one year of a final and binding decision of the Board of Trustees on your claim or appeal; see page 50.)

This written explanation of the Eligibility Committee's decision will be provided to you within 72 hours from the receipt of the appeal for urgent care claim appeals, within 15 days for pre-service claim appeals, within 30 days for post-service claim appeals, and prior to termination of the benefit for concurrent care claim appeals.

The determination of the Eligibility Committee is appealable to the Appeals Committee. The Appeals Committee is a Committee of the Board of Trustees of the Plan whose members are appointed by the Board of Trustees. The Appeals Committee and the Eligibility Committee are made up of different individuals; there is no overlap. After the written explanation concerning the Eligibility Committee's determination is received, if you believe you are adversely affected by such decision you or a duly authorized representative of your choice may file a request for an appeal to the Appeals Committee.

The request for appeal must be in writing and submitted to the Administrative Office. The request for appeal must be received by the Administrative Office within 180 days from the date of your receipt of the written explanation of the Eligibility Committee's determination. Late requests may be rejected as untimely. You may submit any additional evidence or argument to support your position. You may also be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits.

The request for appeal must contain an outline of the matter involved along with any issues, comments or explanations of the applicant's position. Additional written documentation may also be submitted. The applicant may also request that the applicant and/or the applicant's authorized representative be present at the Appeals Committee meeting. A notification of the meeting date and time will then be sent to the applicant who asks for an appearance. Additional evidence can be presented at the Appeals Committee meeting.

The Appeals Committee will independently consider the appeal using the written application presented by you, and/or by hearing the appeal of the individual who has requested a personal appearance at the Appeals Committee hearing. You will be advised in writing of the decision of the Appeals Committee. This will include specific reasons and references to pertinent Plan provisions or documents on which the decision is based; a statement of your rights to receive, upon request and free of charge, reasonable access to, and copies, of all documents, records, and other information relevant to your Claim; and a statement of your right to bring a civil action under Section 502(a) of ERISA. (Civil actions must be brought within one year of a final and

binding decision of the Board of Trustees on your claim or appeal; see page 50.)

The decision of the Appeals Committee is final and binding upon the applicant.

The decision of the Appeals Committee will be given to you in writing within 15 days from receipt of the appeal for pre-service and urgent care Claim appeals, within 30 days for post-service Claim appeals, and prior to termination of the benefit for concurrent care Claim appeals.

This appeals procedure shall be the sole and exclusive procedure available to an individual who is dissatisfied with a Claim or eligibility decision of any kind relating to a covered Claim. The Plan's appeals procedures must be exhausted before the applicant can avail himself of any procedure outside of the rules and regulations of the Plan itself. However, with respect to urgent care Claims only, applicants need not file an appeal with the Appeals Committee before resorting to outside procedures; in such instances the decision of the Eligibility Committee shall be considered the final decision of the Plan binding upon the applicant.

Elimination of Conflict of Interest

To ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators and medical experts) act independently and impartially, decisions related to those persons' employment status (such as decisions related to hiring, compensation, promotion, termination, or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

Review Process

All appeals will be reviewed and decided by the Plan's third-party vendors or by the Appeals Committee of the Board of Trustees of the Plan. The Appeals Committee has full discretionary authority to determine all questions of eligibility for benefits, including the discretionary authority to make all factual determinations and to construe any terms of the Plan. The Appeals Committee will decide all second-level appeals.

For all appeals, claimants may submit written comments, documents, records, and other information relating to the claim for benefits.

For all appeals, a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. A document, record, or other information is relevant to a claim if it:

- Was relied on in making the benefit determination;
- Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether it was relied upon in making the benefit determination;
- Demonstrates compliance with the Plan's administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing Plan documents and that, where appropriate, Plan provisions have been applied consistently with respect to similarly situated claimants; or
- Constitutes a statement of policy or guidance with respect to the Plan concerning any denied treatment option or benefit for the claimant's diagnosis, without regard to whether

such advice or statement was relied upon in making the benefit determination.

Review of all appeals shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

New or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim, regardless of whether it was relied upon in making the benefit determination, will be provided to the claimant free of charge. The Plan will provide the information as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Benefit Determination is required to be provided.

Review of all appeals will afford no deference to the initial Adverse Benefit Determination (or to the previous appeal decision, in the case of a second level appeal).

No appeal decision will be made by the individual who made the Adverse Benefit Determination that is the subject of the appeal (or by any individual who decided a previous level of appeal), or by a subordinate of any such individual.

In all appeals, if the Adverse Benefit Determination was based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, investigational, or not Medically Necessary, the appropriate named fiduciary handling the appeal shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional engaged for the purpose of providing this medical review will not be the individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the review (or who was consulted in connection with a prior level of review), nor the subordinate of any such individual.

In all appeals, the claimant shall be provided, upon request and free of charge, with notice of the identity of any medical or vocational experts whose advice was obtained in connection with the claimant's Adverse Benefit Determination (or in connection with any prior level of review), without regard to whether the advice was relied upon in making the benefit determination.

Time Frames for Notice of Decision on Appeal

You will receive notice of the decision made on your appeal according to the following timetable:

- **Pre-service claims:** You will be sent a notice of a decision on review within **15 days** of receipt of the appeal by the Administrative Office (1st-level appeal) and 15 days of receipt of the appeal by the Administrative Office (2nd-level appeal).

- **Urgent care claims:** You or your representative will be notified of the determination as soon as possible but no later than 72 hours after receipt of the appeal.

- **Concurrent care decisions:** You will receive notice of a decision on review **before reduction or termination** of a treatment in progress.

- **Post-service claims:** Ordinarily, decisions on first-level appeals involving post-service claims will be made by the Eligibility Committee within 30 days after receipt of the appeal. Decisions on second-level appeals to the Appeals Committee will ordinarily be decided at the next regularly scheduled meeting of the Appeals Committee of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 15 days of the next regularly scheduled meeting, your request for review may be considered at the second regularly scheduled meeting of the Eligibility Committee following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

The decision on any review of your claim will be given to you in writing. The written notice will contain the following:

- Information sufficient to identify the claim involved (including the date of service, the health care Provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

- Whether, and the extent to which, the original Adverse Benefit Determination is upheld or reversed;

- A discussion of the decision;

- If the Adverse Benefit Determination is upheld, in whole or in part, the notice will state the specific reason or reasons for the adverse determination including the denial code and its corresponding meaning;

- Reference to the specific plan provisions on which the benefit determination is based;

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

- A description of available external review processes, including how to initiate an external review;

- The availability of, and contact information for, any applicable office of health insurance consumer assistance to assist individuals with the internal claims and appeals and external review processes;

- A statement of the claimant's right to bring an action under section 502(a) of ERISA following exhaustion of administrative remedies;

- If the original Adverse Benefit Determination is upheld, in whole or in part, the notice

will state whether an internal rule, guideline, protocol, or other similar criterion was relied upon in making any adverse determination, and if so, either the specific rule, guideline, protocol, or other similar criterion, or a statement that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request; and

- If the original Adverse Benefit Determination is upheld, in whole or in part, and if the Adverse Benefit Determination is based on a Medical Necessity or Experimental treatment or similar exclusion or limit, the notice will contain an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances.

The decision of the Appeals Committee is the final internal Adverse Benefit Determination and is binding on the Plan. Following a final internal Adverse Benefit Determination, if the claimant continues to believe that the decision is contrary to the terms of the Plan, he or she has the right to request an external review or bring a civil action challenging the decision under section 502(a) of ERISA, 29 U.S.C. §1132(a). However, no legal or equitable action for benefits under the Plan may be brought unless and until the final internal Adverse Benefit Determination has been completed and a decision rendered. Any suit or claim must be filed within one year of the decision of the Appeals Committee (see page 50).

If the Plan fails to strictly adhere to all of the above requirements, the claimant is deemed to have exhausted the internal claims and appeals process. The claimant can then pursue an external review or sue under section 502(a) of ERISA on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim. If a claimant chooses to sue under Section 502(a) of ERISA, the claim or appeal is deemed denied on review without exercise of discretion by an appropriate fiduciary. However, the claimant will not be deemed to have exhausted the internal claims and appeals process if the failure to strictly adhere to all of the requirements consists of de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant.

External Review of Denied Claims

Time Frame and Procedures for Standard External Review

External Review Procedures: Your Obligations. You may request an external review, by an Independent Review Organization ("IRO"), only in the situation where your appeal of a health care claim, whether urgent, concurrent, pre-service, or post-service claim, is denied and it fits within the following parameters:

- The denial 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, an adverse determination related to coverage of routine costs in a clinical trial, or a determination that a treatment is experimental or investigational. The IRO will determine whether a denial involves a medical judgment; and/or

- The denial is due to a Rescission of coverage (retroactive elimination of coverage),

regardless of whether the Rescission has any effect on any particular benefit at that time.

External review is not available for any other types of denials or if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan.

The Plan assumes responsibility for fees associated with External Reviews. Generally, you may only request external review after you have exhausted the internal claims and appeals process described above. This means that, in the normal course, you may only seek external review after a final determination has been made on an appeal. For more information about the External Review procedures, contact the Administrative Office.

A request for an external review must be submitted, in writing, by the claimant, his authorized representative or PPO Provider, to the Plan within four months after the date of receipt of a notice of an Adverse Benefit Determination or final internal Adverse Benefit Determination. Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether the request is eligible for external review.

Within one business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant.

If the request is complete and eligible for external review it will be sent to an Independent Review Organization (IRO) for review. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and contact information for any applicable office of health insurance consumer assistance. If the request is not complete, the notification will describe the information or materials needed to make the request complete. In addition, the Plan will allow a claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. The notice will include a statement that the claimant may submit in writing to the assigned IRO additional information that the IRO must consider when conducting the external review; however, the additional information must be received within 10 business days following the date of receipt of the notice.

The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and 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 assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- The claimant's medical records;
- The attending health care professional's recommendation;
- Reports from the appropriate health care professionals and other documents submitted by the Plan, claimant, or the claimant's treating provider;
- The terms of the claimant's plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;

- 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;
- Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
- The opinion of the IRO's clinical review or reviewers to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the claimant and the Plan.

The assigned IRO's decision notice will contain:

- 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), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
- The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- 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;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or the claimant;
- A statement that judicial review may be available to the claimant; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance.

After a final external review decision, an IRO must make records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where disclosure would violate State or Federal privacy laws.

Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or final internal Adverse Benefit Determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Time Frame and Procedures for Expedited External Review

A claimant may request an expedited external review with the Plan at the time the claimant receives:

- An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has

requested a request for an expedited internal appeal; or

- A final internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received Emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, the Plan must determine whether the request meets the reviewability requirements for standard external review. The Plan must immediately send a notice to the claimant of its eligibility determination.

Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO. The Plan must provide all necessary documents to the assigned IRO as expeditiously as possible.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents submitted. In reaching a decision, the assigned IRO must 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 assigned IRO must provide notice of the final external review decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the Plan.

Appeals of Adverse Benefit Determinations Made by Third Party Vendors

A claimant has a right to request a review of any benefits administered by any third party vendor that makes Adverse Benefit Determinations, which may include third party administrators such as: the medical claims administrator, the Pharmacy Benefits Manager, and any managed care program administrator. As to all such benefits administered by any third party vendor making any Adverse Benefit Determination, the claimant's right to request a review shall be determined under the agreement between the Plan and the third party vendor, which decision shall comply with all applicable law.

If a claimant disagrees with the appeal decision of the vendor, the claimant may file a second level of appeal to the Health and Welfare Plan's Appeals Committee but only as to self-funded prescription drug claims administered by Express Scripts.

Second-level appeals must be filed with the Administrative Office within 60 days after the claimant receives notification of the decision on the first-level appeal. In order to exhaust the claimant's administrative remedies, the claimant must file a second-level appeal.

The Appeals Committee will make a decision on the second-level appeal of an Adverse Benefit Determination within the timeframes specified above. See the section "Time Frames for Notice of Decision on Appeal."

Following exhaustion of the internal appeal procedure, if the claimant continues to believe that the decision is contrary to the terms of the Plan, he or she has a right to request an external review or bring a legal or equitable action for benefits under Section 502(a) of ERISA. No action for benefits may be brought against the Plan unless and until the second-level internal appeal has been completed and a decision rendered. Any suit or claim must be filed within one year of the decision of the Appeals Committee.

If the Plan fails to strictly adhere to all the foregoing appeals requirements, the claimant is deemed to have exhausted the internal claims and appeals process. The claimant can then pursue an external review or sue under 502(a) of ERISA on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim. If a claimant chooses to sue under 502(a) the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary. However, the claimant will not be deemed to have exhausted the internal claims and appeals process if the failure to strictly adhere to all of the requirements are de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant.

Deadline for Filing Suit Following Denial of Appeal (or Denial of Claim in no Appeal): Any civil action under Section 502(a) of ERISA, challenging an actual or perceived denial of a claim for eligibility or benefits under this Plan, in whole or in part, must be filed within one year of the date of a final and binding decision of the Board of Trustees denying the claim or an appeal relating thereto. If no appeal was filed, even though appeals are required as a condition of filing suit, then suit must be brought within one year of the date of the Plan's denial of the claim.

THIRD PARTY LIABILITY

If you receive a recovery from any source whatsoever, including, but not limited to, first party uninsured motorist coverage and/or third party liability coverage (auto accident, Worker's Compensation, or other), the Plan is entitled to recover the amount of benefits paid under the Plan.

Benefits will be provided under the Plan due to injury or illness caused by the act or omission of another only on the condition that you:

- agree, before any benefits are paid, to reimburse the Plan, to the extent of benefits provided by the Plan, immediately upon receipt of payments made by or on behalf of persons causing such injury. This provision shall be binding on the heirs, beneficiaries, personal representatives, or estates of the injured person, whether such payments are a result of judgment, settlement, compromise, or otherwise, and

- execute and deliver to the Plan a lien, to the extent of the dollar amount of benefits provided by the Plan. Such lien shall be a lien upon any proceeds which shall be received by the injured person, his or her heirs, beneficiaries, personal representatives, or estate, and which proceeds are paid by reason of any judgment, settlement, compromise, or otherwise. Such lien may be filed with any person, organization, or otherwise, including any court of competent jurisdiction, to protect the interests of the Plan.

The participant and/or injured person, his or her heirs, beneficiaries, personal representatives, attorneys, or estate, shall execute such documents as the Trustees of the Plan may require in order to acknowledge and evidence the rights of the Plan as set forth in this section, and shall do nothing to prejudice such rights.

Obligation to Repay the Plan Out of Third Party Recoveries

When a person accepts eligibility status by enrolling in the Plan, this means the individual agrees to repay to the Plan the amount of expenses paid by the Plan for an accident or illness affecting the individual, to the extent the individual recovers money from any third party or other source, such as the individual's own insurance as a result of such illness or injury.

More specifically, when a person accepts eligibility status under the Plan, such individual agrees, on behalf of such individual and any individual or entity claiming through such individual (such as an heir, a beneficiary, a personal representative, the individual's estate, a trust, an assignee, or any other person deriving rights from the individual) (a "Payee"), that if any payments are received or receivable by or for the benefit of such Payee from any source whatsoever (including without limitation the Payee's own insurance respecting uninsured or underinsured motorists, medical or no-fault benefits payable), which are, in whole or in part, to recompense the Payee for an injury or illness for expenses have been, or may be, paid by the Plan (the "Gross Recovery"), such Payee is obligated to repay the Plan, out of the first Gross Recovery proceeds payable, the amount paid by the Plan to, or on behalf of, the Payee under the Medicare Supplement option or Fee-For-Service Comprehensive Medical option, for expenses arising from that injury or illness, up to the amount of the "Net Recovery." The Payee further agrees that the Plan shall have an automatic contractual security interest in the Net Recovery and the right to receive it until the Plan's right to repayment is satisfied. The Payee further agrees as a condition to receipt of benefits under the Plan to execute and deliver to the Plan upon the Plan's demand a lien agreement granting a security interest in the Gross Recovery and the right to receive it until the Plan's right to repayment is satisfied.

"Net Recovery" means the Gross Recovery reduced by the following expenses paid or payable in cash by, or on behalf of, the Payee, to the extent the Plan in its discretion determines them to be necessary to obtain the Gross Recovery, and reasonable in amount:

- attorney's fees, not to exceed thirty percent of the Gross Recovery, required to obtain the Gross Recovery,

- costs and expenses for medical care arising out of the illness or injury not otherwise payable by the Plan,

- other costs and expenses paid by the Payee, required to obtain the Gross Recovery.

The Payee will be required to submit any and all documentation to the Administrative Office or Plan counsel that the Plan deems necessary to verify the calculation of the Net Proceeds.

Upon acceptance of the relevant eligibility status, including by enrollment in the Plan, and as a condition thereto, the Payee agrees to the repayment right of the Plan as described above. In addition, if Plan counsel so requests, the Payee will be required to sign supplemental contractual documents satisfactory to the Plan further obligating the Payee to satisfy the Plan's

reimbursement rights as described above and in such further specificity as such documents shall provide. If the Payee fails to sign the lien agreement or these documents, or otherwise materially fails to fulfill the reimbursement obligation described in the first sentence of this paragraph, the eligibility status of the Payee and any other individual whose status as such is conferred by, or derived from, the Payee, shall be terminated upon written notice from the Plan, and no reimbursements by or on behalf of such Payee shall be paid by the Plan thereafter respecting such former eligible individual pending satisfaction of the Plan's repayment right as described in this paragraph.

DISCLAIMERS

- None of the benefits described in this booklet are insured by any contract of insurance, and there is no liability on the Board of Trustees or any individual or entity to provide payment over and beyond the amounts in the Plan collected and available for such purposes.

- The only sources of authorized information are this SPD, the providers' benefit booklets, and booklet inserts, if any, the Trust Agreement for the Health Plan, the Service Agreements between the Plan and Express Scripts and Anthem Blue Cross, the written statements of the Plan Administrative Office on behalf of the Plan, and the written statements of duly authorized representatives of Anthem Blue Cross with respect to benefits and coverages under those plans.

- Your rights with respect to eligibility and benefits under the Plan are determined by the agreements with service providers and the Plan's eligibility and benefit provisions as set forth in this booklet, and any booklet inserts, relating to the hospital, medical, and prescription drug benefits provided directly by the Plan. In the event of any conflict between the provisions contained in the agreements with service providers and the provisions contained in this booklet, including any inserts, the provisions contained in this booklet and inserts shall prevail.

- Participants have no accrued or vested rights to benefits under the Plan. In the event the Plan is terminated by the Board of Trustees, the rights of all participants covered under the Plan with respect to any benefits available subsequent to termination, will be determined by the Board of Trustees, in its sole and absolute discretion in accordance with procedures specified in the Trust Agreement.

- The Board of Trustees expressly reserves the right at any time and from time to time for any reason, in its sole and absolute discretion, in accordance with the procedures specified in the Trust Agreement:

    - to terminate or amend the amount or eligibility conditions with respect to any benefit, to terminate or change any benefit, or to add or modify any self-payment, even though such changes may affect claims which have already accrued,

    - to terminate the Plan and/or any other health coverage offered through the Plan even though such termination affects claims which have already accrued,

- to alter or postpone the method of payment of any benefit, or

- to amend or rescind any other provision of the Plan.

➢ If you or a provider call the Administrative Office to inquire about eligibility or benefits, the Administrative staff can only describe Plan benefits and verify eligibility, in general, based upon information provided, thus far, and subject to all terms of the Plan. Verification does not guarantee reimbursement or validation of eligibility or approval of specific coverage or benefits. Before final determination is made, claims are subject to routine review.

➢ Neither the Plan, its Board of Trustees, or any of their designees are engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any health care provider. Neither the Plan, its Board of Trustees, nor any of their designees, will have any liability whatsoever for any loss or injury caused to a Plan participant or beneficiary by any health care provider by reason of negligence, failure to provide care or treatment, or otherwise.

➢ The Fee-For-Service Comprehensive Medical option referenced in this booklet covers, in general, all medically necessary services and supplies (as determined by the Board of Trustees) unless excluded under its terms.

➢ ALL SERVICES ARE SUBJECT TO RETROSPECTIVE REVIEW BY AN INDEPENDENT MEDICAL CONSULTANT TO DETERMINE IF THEY ARE COVERED SERVICES.

GENERAL PLAN PROVISIONS

Payment of Benefits

All benefits will be paid by the Plan to the participant as they accrue upon receipt of written proof, satisfactory to the Plan, covering the occurrence, character, and extent of the event for which the Claim is made and of payment due the participant for the Covered Services.

Assignment of Benefits

Benefits payable hereunder shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person. However, any participant may direct that benefits due him/her be paid to an institution in which he/she or his/her dependent is hospitalized, or to any provider of medical or dental services or supplies in consideration of medical or dental services rendered or to be rendered.

Payment of Benefits under Special Circumstances

In the event the Board of Trustees determines that the participant is incompetent or incapable of executing a valid receipt or assignment and no guardian has been appointed, or in the event the participant has not provided the Plan with an address at which he/she can be located for payment, the Plan may, during the lifetime of the participant or surviving spouse, pay any amount otherwise payable to the participant, to the husband or wife or relative by blood of the participant, or to any other person or institution determined by the Plan to be equitably entitled thereto; or in the case of the death of the participant before all amounts payable under the Plan have been paid, the Plan may pay such amounts to any person or institution determined by the Trustees to be equitably entitled thereto. The remainder of such amounts shall be paid to one or more of the following surviving relatives of the participant: legal spouse, child or children, mother, father, brothers or sisters, or to the participant's estate, as the Trustees in their sole discretion may designate. Any payment in accordance with this provision shall discharge the obligation of the Plan hereunder to the extent of such payment.

Physical Examination and Autopsy

The Plan, at its own expense, shall have the right and opportunity to examine the person of any participant or dependent when and as often as it may reasonably require during the pendency of any Claim. If a person refuses examination, the Plan reserves the right to deny benefits. The Plan shall also have the right and opportunity to require an autopsy in case of death, where it is not forbidden by law. Proof of claim forms, as well as other forms, and methods of administration and procedure, will be solely determined by the Plan.

Discretionary Authority

In carrying out their respective responsibilities under the Plan, the Board of Trustees, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force

and effect. The Board of Trustees retains the sole and absolute discretion to interpret the provisions of the Plan and to make the necessary factual determinations regarding eligibility for, or amount of benefits or any other issue regarding the Plan.

Worker's Compensation Not Affected

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

Trust Agreement

The provisions contained in this booklet and booklet inserts, if any, are subject to and controlled by the provisions of the Trust Agreement under which the Plan is established and maintained. In the event of any conflict between the provisions contained in this SPD and booklet inserts and the provisions contained in the Trust Agreement, the provisions of the Trust Agreement shall prevail.

Right to Receive and Release Necessary Information

For the purpose of determining eligibility and benefits payable under the Plan, the Administrative Office may, with the consent of the participant and consistent with applicable law, release to or obtain from an insurance company, employer, or other organization or person, any information with respect to any person which the Plan's Administrative Office deems to be necessary for such purposes. Any participant or dependent claiming benefits under the Plan must furnish to the Plan's Administrative Office all such information as may be necessary to implement this provision.

Right of Recovery

Whenever payments have been made by the Plan, at any time, in excess of the amount of payment that should have been made at that time to satisfy the benefit provisions of the Plan, the Plan shall have the right to recover such payments to the extent of such excess, in addition to any necessarily incurred attorney's fees and costs of suit, through any legal or equitable means from among one or more of the following, as the Trustees shall determine:

- any person to or for or with respect to whom such payments were made, including offsetting benefit payments, or
- any other plan.

In addition, in the event that you make an intentional misstatement of material fact, omit to state a material fact, or commit an act of fraud or dishonesty to the detriment of the Plan, you or your dependents (or any individual claiming to be a dependent through you) will lose all rights to eligibility that you might otherwise have had under the Plan, retroactive to the date of the offending act. Loss of eligibility for one of these reasons is not an event resulting in a right to COBRA continuation coverage.

Delinquent Owner-Participants

If a participant or spouse has a five percent (5%) or greater ownership interest in the employer contributing on the participant's behalf, no claims or premiums will be paid, nor will COBRA continuation coverage be available, for that individual or his or her dependents if the employer is delinquent in payment of any contributions or any other amounts due to any employee benefit plan under the Collective Bargaining Agreements.

Alternative Treatment

In managed care cases, the Board of Trustees expressly reserves the right, in its sole and absolute discretion, to provide Plan coverage for services and supplies which are not ordinarily covered under the terms of the Plan if such services or supplies are in lieu of services or supplies ordinarily covered under the terms of the Plan and are recommended by the Plan's Utilization Review Firm.

Headings Do Not Modify Plan Provisions

The headings of chapters, subchapters, sections, paragraphs, and subparagraphs are included for the sole purpose of generally identifying the subject matter of the substantive text so that a table of contents can be constructed for the convenience of the reader. The headings are not part of the substantive text of any provision, and they should not be construed to modify the text of any substantive provision in any way.

Pronouns

All pronouns and any variations thereof refer to and include the masculine, feminine, neuter, singular, or plural, as the context may require.

YOUR RIGHTS UNDER ERISA

As a participant in the Sheet Metal Workers' Health Plan of Southern California, Arizona and Nevada, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to the following rights:

Receive Information about Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Administrative Office and at other specified locations, such as worksites and union halls, all documents governing the operation of the Plan. These documents include insurance contracts and Collective Bargaining Agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefits Administration).

- Obtain, upon written request to the Administrative Office, copies of documents governing the operation of the Plan. These include insurance contracts, Collective Bargaining Agreements, copies of the latest annual report (Form 5500 Series), current Plan Document with amendments and updated Summary Plan Description. The Plan 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 Chapter 1 of this SPD booklet, or HMO booklets, for the rules governing your COBRA continuation coverage rights (and in the case of HMO coverage, Cal-COBRA rights).

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 employee benefit plans. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

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

Assistance with Your Questions

If you have any questions about your plan, you should contact the Administrative Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA) (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory. Alternatively, you may obtain assistance by calling EBSA toll-free at (866) 444-EBSA (3272) or writing to the following address:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of EBSA. For single copies of publications, contact the EBSA brochure request line at (800) 998-7542 or contact the EBSA field office nearest you.

You may also find answers to your Plan questions and a list of EBSA field offices at the website of EBSA at http://www.dol.gov/ebsa.

PLAN FACTS

- **NAME OF PLAN:** The Plan is known as the Sheet Metal Workers' Health Plan of Southern California, Arizona and Nevada. The Plan described in this booklet covers retired participants and their dependents under the Retiree Health Plan's Medicare Supplement option or Fee-For-Service Comprehensive Medical option.

- **PLAN SPONSOR AND ADMINISTRATOR:** The Board of Trustees is both the Plan Sponsor and Plan Administrator. This means that the Board of Trustees is responsible for seeing that information regarding the Plan is reported to governmental agencies and disclosed to Plan participants and beneficiaries in accordance with the requirements of the Employee Retirement Income Security Act of 1974, as amended.

  The Plan is administered and maintained by the Board of Trustees. The routine functions of the Plan are performed by:

  Sheet Metal Benefit Plans Administrative Corporation
  111 North Sepulveda Blvd., Suite 100
  Manhattan Beach, CA 90266

- **IDENTIFICATION NUMBER:** The number assigned to the Plan by the Internal Revenue Service is 95-6052259. The number assigned to the Plan is 501.

- **AGENT FOR SERVICE OF LEGAL PROCESS:** The name and address of the agent

designated for the service of legal process is:

Vernon Shaffer, Executive Director
Sheet Metal Benefit Plans Administrative Corporation
111 North Sepulveda Blvd., Suite 100
Manhattan Beach, CA 90266

Legal process may also be served on a Plan Trustee.

- **COLLECTIVE BARGAINING AGREEMENTS AND PARTICIPATION AGREEMENTS:** Contributions to the Plan are made on behalf of each employee in accordance with collective bargaining agreements between the Sheet Metal Workers' International Association, local unions and employers in the industry and/or in accordance with participation agreements between such employer and the Plan.

- **SOURCE OF CONTRIBUTIONS:** The benefits described in this booklet are provided through employer contributions and participant self-pay contributions. The amount of employer contributions is determined by the provisions of the collective bargaining agreements or participation agreements with employers or employer representatives. The amount of self-pay contributions is determined in the sole and absolute discretion of the Board of Trustees.

- **TYPE OF PLAN:** The Retiree Health Plan is maintained for the purpose of providing Hospital, Medical, and Prescription Drug benefits in the event of sickness or injury.

- **HEALTH PLAN:** All assets are held in trust by the Board of Trustees of the Sheet Metal Workers' Health Plan of Southern California, Arizona and Nevada and invested in various bank savings accounts and short-term bank investments, government and corporate bonds and certain other investments approved by the Trustees.

- **IDENTITY OF PROVIDER OF SERVICES OR BENEFITS:** All of the benefits described in this booklet are provided directly from the Plan itself. The Plan has administrative service agreements with Express Scripts for its prescription drug coverage and Anthem Blue Cross for its utilization review and PPO program applicable to the Fee-For-Service Comprehensive Medical option.

  The names and addresses of the service organizations are:

  Anthem Blue Cross
  P.O. Box 60007
  Los Angeles, CA 90060-007
  (800) 274-7767

  Express Scripts
  4700 Nathon Lane North
  Plymouth, MN 55442-2599
  (800) 349-3780

- **PLAN YEAR:** The records of the Plan are kept separately for each Plan Year. The Plan year begins January 1 and ends on December 31.

- **THE PLANS REQUIREMENTS WITH RESPECT TO ELIGIBILITY FOR PARTICIPATION AND BENEFITS:** The eligibility requirements are specified in Chapter 1 of this booklet.

- **CIRCUMSTANCES RESULTING IN DISQUALIFICATION, INELIGIBILITY OR DENIAL OR LOSS OF BENEFITS:** Loss of eligibility is described in Chapter 1 of this booklet.

- **CLAIMS FILING AND CLAIMS APPEAL PROCEDURE:** is described in Chapters 2, 3, and 7 of this booklet.

This booklet contains a summary in English of your plan rights and benefits under the Sheet Metal Workers' Health Plan of Southern California, Arizona and Nevada. If you have difficulty understanding any part of this booklet, contact the Administrative Office at 111 North Sepulveda Blvd., Suite 100, Manhattan Beach, California 90266. The office hours are from 7 a.m. to 5 p.m., Monday through Friday. You may also call the Administrative Office at (800) 947-4338 for assistance.

GLOSSARY OF TERMS USED IN THIS BOOKLET

Listed below are definitions of some of the terms used in this booklet and booklet inserts, if any.

- "**Active Plan**" means the health care options and eligibility rules that have been designated as Plan A or Plan B by the Plan, and which are exclusively provided to eligible active sheet metal workers.

- "**Allowable Charge(s)**" means:

  - **under the Fee-for-Service Comprehensive Medical option**, the dollar amount used by the Plan when calculating a benefit payment under the Plan as follows:

    Allowable Charge with respect to a Covered Service billed by a PPO Provider is the amount specified in the contract between the PPO and the provider.

    Allowable Charge with respect to a Covered Service billed by a non-PPO Provider is the lesser of the provider's usual and customary charge, or the amount specified in the Plan's schedule of allowances. The Plan's schedule of allowances is based on a percentile of provider's fees in the geographical area where services are rendered as reported to the Plan by Ingenix. The Plan's schedule of allowances is not intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary and reasonable (UCR), or any similar term. Should the participant or the provider require a written estimate of allowances for services, please contact the Administrative Office. The Board of Trustees reserves the exclusive right to replace, amend or update the Plan's schedule of allowances at any time and from time to time in its sole and absolute discretion in accordance with procedures specified in the Trust Agreement.

    If a non-PPO Provider charges more than the Allowable Charge, the amount in excess is the responsibility of the participant in addition to any deductible or co-insurance for which the participant is responsible in accordance with the benefit provisions of the Plan.

    In accordance with federal law, with respect to Emergency services performed in a Non-PPO emergency room (ER), the Plan's allowance for ER visit facility fees is to pay according to the billed charges, and the allowance for ER professional fees is the greater of:

    a) the negotiated amount for PPO providers (the median amount if more than 1 amount to PPO providers), or
    b) 100% of the Plan's usual payment (Allowable Charge) formula (reduced for cost-sharing), or
    c) when such database is available, the amount that Medicare Parts A or B would pay (reduced for cost sharing).

    Under no circumstances will the Plan pay more than what is actually charged by a PPO or non-PPO Provider.

- **under the Medicare Supplement option**, the dollar amount allowed by Medicare for providers who accept Medicare's assignment of benefits for Covered Services, whether or not the specific provider accepts such assignment. **If any provider charges more than the amount allowed by Medicare for providers who accept Medicare's assignment, the amount in excess is your responsibility, in addition to any deductible or co-insurance for which you may be responsible in accordance with the benefit provisions of the Medicare Supplement option.**

➢ "**Board of Trustees**" means the Board of Trustees of the Sheet Metal Workers' Health Plan of Southern California, Arizona and Nevada.

➢ "**Contributing Employer**" means an employer required by a collective bargaining agreement with a participating local union or applicable law to make contributions to the Plan. "Contributing Employer" also means an employer that has agreed to contribute to the Plan on the same basis as any Contributing Employer and that has been approved by the Board of Trustees to participate in the Plan.

➢ "**Cosmetic Surgery or Treatment**" means surgery or medical treatment solely or primarily to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to, removal of tattoos, breast augmentation except as required by the Women's Health and Cancer Rights Act of 1998, or other medical, dental or surgical treatment intended to restore or improve physical appearance, as determined by the Board of Trustees or its delegate.

➢ "**Covered Service(s)**" means:

- **under the Fee-For-Service Comprehensive Medical option,** those services or supplies which are medically necessary and reasonable and customary for the diagnosis or treatment of the illness or injury being treated for which benefits are provided under the Plan, as determined in the sole and absolute discretion of the Board of Trustees. The fact that a procedure or level of care is prescribed by an Eligible Provider does not mean that it is medically necessary or that it is covered by the Plan. Services that are not medically necessary and reasonable and customary shall include, but are not limited to, the following:

  i. procedures which are of unproven medical value or of questionable current therapeutic usefulness,
  ii. procedures which tend to be redundant when performed in combination with other procedures,
  iii. diagnostic procedures which are unlikely to provide an Eligible Provider with additional information when they are used repeatedly,
  iv. procedures which are not prescribed by an Eligible Provider or which are not documented at the time services are rendered in the patient's medical file,
  v. procedures or hospitalization which can be performed with equal efficiency at a lower level of care, or
  vi. procedures or confinement, which are considered by the Plan to be Custodial Care, Cosmetic Surgery or Treatment or Experimental.

- **under the Medicare Supplement option,** those services or supplies that are covered by Medicare Part A or Part B.

➢ "**Custodial Care**" means care rendered to a person who:

- is mentally or physically disabled and such disability is expected to continue and be prolonged, and
- requires a protected, monitored or controlled environment whether in an institution or in the home, and
- requires assistance to support the essentials of daily living, and
- is not under active or specific medical, surgical or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored or controlled environment.

➢ "**Eligible Provider**" means a licensed or certified health care practitioner acting within the scope of his/her license and whose professional credentials are recognized by the Plan as sufficient to provide care for which benefits may be provided.

➢ "**Emergency**" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious harm.

➢ "**EPO**" means Exclusive Provider Organization.

➢ "**Experimental**" means any procedure, treatment, therapy, drug, biological product, facility, equipment, device, or supply which the Board of Trustees or its delegate has determined, in its sole discretion, not to have been demonstrated as safe and effective as compared with the standard means of treatment or diagnosis. "Experimental" also means any procedure, treatment, therapy, drug, biological product, facility, equipment, device, or supply that is determined by the Board of Trustees or its delegate to be investigational, educational, or the subject of current clinical trials.

When making a determination under this definition, the Board of Trustees or its delegate shall refer to reliable evidence, which may be derived, without limitation, from one or more of the following sources:

- published, authoritative peer-reviewed medical and scientific literature regarding the procedure at issue as applied to the injury or illness at issue,
- publications and evaluations from national medical associations, such as the American Medical Association or specialty medical associations,
- regulations and other official guidelines or publications issued by the U.S. Food and Drug Administration (FDA) or Department of Health and Human Services, and
- written protocols and consent forms used by the treating facility or by another facility administering substantially the same drug, device or medical treatment.

For the Board of Trustees or its delegate to determine that the service or supply is safe and effective as compared with the standard means of treatment or diagnosis, the service or supply must meet all of the following applicable criteria:

- reliable evidence must conclusively show that the service or supply is recognized as approved, in accordance with generally accepted standards in the national medical community, as being safe and effective for use in the treatment or diagnosis of the illness, injury, or condition at issue,
- any required approval of any Federal government or agency, or any State government or agency, must have been obtained prior to the time of use,
- if it is a drug or device that cannot be lawfully marketed without the approval of the FDA, final approval must have been obtained at the time the drug or device is furnished. Interim FDA approvals for a Phase I, II or III trial, pre-market approval applications, and investigational exemptions are not sufficient. If final FDA approval has been obtained, only the uses and indications for which the drug or device was licensed are Allowable Charges.

Notwithstanding the foregoing, a service or supply shall be considered Experimental

- if the service or supply is provided pursuant to a Phase I or Phase II clinical trial or as the experimental or research arm of a Phase BI clinical trial,
- if it is under study to determine maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnose, or
- if its safety or efficacy, or efficacy as compared with the standard means of treatment or diagnosis, is the subject of substantial debate within the national medical community.

The fact that a Physician or other medical professional or expert may prescribe, order, recommend, recognize, or approve any procedure, treatment, therapy, drug, biological product, facility, equipment, device, or supply, does not in itself make the service or supply non-Experimental within the meaning of this definition. Similarly, the fact that the service or supply is authorized by law or otherwise for use in testing, trials, or other studies on human patients shall not in itself make the service or supply non-Experimental within this definition. Routine care associated with certain clinical trials is covered to the extent required by the Affordable Care Act.

➢ "**Extended Care Facility**" also referred to as a "Rehabilitation Facility," means only an institution which meets all of the following requirements:

- is primarily engaged in providing injured, disabled or sick inpatients with skilled nursing care and related services for patients who require medical or nursing care or rehabilitation,
- is regularly engaged in providing skilled nursing care for sick and injured persons under 24 hours a day supervision of a Physician or a Registered Nurse,
- has available at all times the services of a Physician who is a staff member of a Hospital,
- has on duty 24 hours a day a Registered Nurse, or has on duty 24 hours a day a licensed vocational nurse or skilled practical nurse and it has a Registered Nurse on duty at least eight hours per day,
- maintains a clinical record for each patient,
- is not, other than incidentally, a place for rest, a place for Custodial Care, a place for the aged, a place for drug addicts, a place for alcoholics, a hotel, or a similar institution, and
- complies with all licensing and other legal requirements and is recognized as an "extended care facility" by Medicare.

- "**Home Health Care**" means professional medical care rendered by an Eligible Provider in a patient's home.

- "**HMO**" means Health Maintenance Organization.

- "**Hospice Care**" means a method of caring for the terminally ill that helps those individuals continue their lives with as little disruption as possible. In order to be considered terminally ill, the individual must have a medical prognosis of six months or less to live. The care may include the following services and supplies:

  - nursing care provided under the supervision of a Registered Nurse,
  - physical therapy, occupational therapy and speech pathology,
  - medical social services under the direction of a Physician,
  - services of a home health aide who has successfully completed a training program approved by Medicare,
  - homemaker services,
  - medical supplies and the use of medical appliances,
  - Physicians' services,
  - short-term inpatient care (including procedures necessary for pain control and acute and chronic symptom management) in an appropriate inpatient facility such as a participating Hospital or nursing home that meets hospice qualification requirements. However, respite care may be provided only on an intermittent, non-routine and occasional basis and may not be provided consecutively over longer than five days.

  The care and services described in the first four items above may be provided on a 24 hour, continuous basis only during periods of crisis and only as necessary to maintain the terminally ill individual at home.

  The hospice program must provide care and services in the patient's home. Inpatient care is allowable but only on a short-term basis.

  In addition, a covered hospice program must 1) have an inter-disciplinary staff including at least one Physician and one Registered Nurse, that provide the required care and services; 2) maintain central clinical records on all patients; 3) utilize volunteers; 4) meet applicable state and local licensing laws; and 5) maintain management responsibility for all hospice services provided to the patient, regardless of the location or facility in which the services are furnished.

- "**Hospital**" means only an institution which meets all of the following requirements:

  - maintains permanent and full-time facilities for bed care of five or more patients,
  - has a Physician in regular attendance,
  - continuously provides 24 hours a day nursing services by Registered Nurses,
  - is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care of injured and sick persons on a basis other than as a rest home, nursing home, convalescent home, or a place for the aged, and
  - is operating lawfully in the jurisdiction in which it is located, thus qualifying under the term "legally operated hospital."

The term "Hospital" shall include a state licensed acute psychiatric hospital.

- "**Non-Covered Sheet Metal Service**" means sheet metal work in the geographical jurisdiction of the Sheet Metal Workers' Pension Plan of Southern California, Arizona and Nevada or a related plan (one linked by reciprocal agreements – for more information contact the Administrative Office) for an employer which does not have, or, self-employment which is not covered by, a collective bargaining agreement with a Sheet Metal Workers' union which requires contributions to the Pension Plan or a related plan. It includes all work or services of the kind performed by any Contributing Employer to the Pension Plan that relates in any way to any work of the kind performed by participating employees covered by the Pension Plan. It includes such jobs as management, ownership (including by your spouse), sales, estimating, or consulting positions for Sheet Metal employers or in the Sheet Metal Industry, as well as work of the type done by bargaining unit members and related work.

- "**Pension Benefit(s)**" means a monthly pension benefit from the Sheet Metal Workers' Pension Plan of Southern California, Arizona and Nevada.

- "**Pension Plan**" means the Sheet Metal Workers' Pension Plan of Southern California, Arizona and Nevada.

- "**Physician**" means a person acting within the scope of his/her license and holding a degree of Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatric Medicine (D.P.M.) or Doctor of Dental Medicine (D.M.D.), who is legally entitled to practice medicine under the laws of the state or jurisdiction where the services are rendered.

- "**Plan**" means the Sheet Metal Workers' Health Plan of Southern California, Arizona and Nevada.

- "**PPO Provider**" means an Eligible Provider, Hospital, or other facility that has a written agreement recognized by the Plan to provide health care services to Plan participants at specified costs.

- **"Psychiatric Care**" means any treatment for any nervous or mental disease or disorder whether the cause is organic, physical, mental or environmental including, but not limited to, a condition which falls within the diagnosis codes 290 through 290.9 and 293 through 302.9 and 306 through 316 as listed in the International Classification of Diseases, 10th Revision, Clinical Modification, Volumes 1 and 2, and any subsequent Revisions or Volumes.

- **"Recognized Provider" means** a Physician, and to the extent benefits are provided by the Plan, shall also include health care professionals when state licensed or certified and when acting within the scope of his or her license or certification.

- "**Registered Nurse**" means a registered graduate nurse, legally licensed.

- "**Retired Participant**" (**or "retired participant"**) means a retired sheet metal worker or other individual who meets the eligibility requirements for coverage under the Retiree Health Plan as a retiree.

- "**Retiree Health Plan**" means the health care options and eligibility rules that have been designated as the Retiree Health Plan by the Plan, and which are exclusively provided to eligible retired sheet metal workers.

- "**Sheet Metal Industry**" means all work or services of the kind performed by any Contributing Employer to the Sheet Metal Workers' Pension Plan of Southern California, Arizona, and Nevada, which relates in any way to any work performed by employees covered by the Pension Plan. For example, in addition to manufacturing, fabrication, service, design and installation of products or goods by Contributing Employers, the Sheet Metal Industry includes, but is not limited to, the following functions:

  - an ownership interest in, or any work or consulting for, any establishment which manufacturers, fabricates, services, designs, installs, repairs or sells any items of the type so handled by any Contributing Employer; whether or not the establishment is incorporated and whether or not it contributes to the Pension Plan. If your spouse has any such connection with the Sheet Metal Industry, you are deemed to also have compensation or profit from the Industry. If your spouse has an ownership interest in a sheet metal employer, you are deemed to also have an ownership interest,
  - acting in a sales, consulting, estimating or design capacity relating to any items of the types manufactured, fabricated, serviced, designed, installed, repaired, sold, etc. by any Contributing Employer, or
  - any other work relating in any way to the manufacture, fabrication, service, design, installation, repair or sale of any item of the type handled by any Contributing Employer.

- "**You**" (**or "you"**) means a retired sheet metal worker, dependent, or other individual who meets the eligibility requirements for coverage under the Retiree Health Plan's Medicare Supplement option or Fee-for-Service Comprehensive Medical option.

MEMBERS OF THE BOARD OF TRUSTEES

The Board of Trustees is responsible for operating the Plan. The Board of Trustees consists of employer and union representatives, selected by the employers and unions in accordance with the Trust Agreement that governs the Plan. If you wish to contact the Board of Trustees, you may use the address of Sheet Metal Benefit Plans Administrative Corporation, 111 North Sepulveda Blvd., Suite 100, Manhattan Beach, California 90266.

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