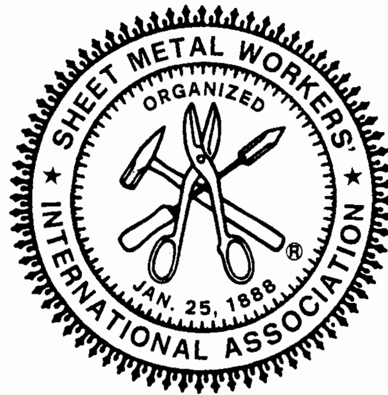
SHEET METAL WORKERS'
HEALTH PLAN OF SOUTHERN CALIFORNIA,
ARIZONA AND NEVADA

RETIREE HEALTH PLAN

FOR PARTICIPANTS RESIDING IN AN
HMO SERVICE AREA

Revised January 1, 2003



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Revised January 1, 2003

If you have questions, please call (800) 947-4338.

AUTHORIZED SOURCE OF INFORMATION

The only sources of authorized information are the benefit booklets and booklet inserts, if any, the Trust Agreement, the Service Agreements between the HMOs and the Trust, the written statements of the Trust Administrative Office on behalf of the Plan, and the written statements of duly authorized representatives of the HMOs with respect to benefits and coverage under the HMOs. Statements or representations made by individuals other than those designated personnel are not authoritative sources of information.

Questions as to eligibility and other related matters should be submitted to the Administrative Office located at 111 North Sepulveda Blvd., Suite 100, Manhattan Beach, California 90266-6861, telephone (800) 947-4338.

Questions as to benefits and other related matters under the HMO plans should be submitted to the respective HMO, as follows:

	Address	Customer Service No.
Kaiser	493 East Walnut, Walnut Center Pasadena, CA 91188	(800) 464-4000 – Non-Medicare Plan (800) 777-1238 – Senior Advantage
PacifiCare of California	5856 Corporate Avenue Cypress, CA 90630	(800) 624-8822 – Non-Medicare Plan (800) 228-2144 – Secure Horizons
PacifiCare of Nevada	700 East Warm Springs Road Las Vegas, NV 89119	(800) 347-8600 – Non-Medicare & Secure Horizons
PacifiCare of Arizona	410 North 44th Street Phoenix, AZ 85072	(800) 342-3347 – Non-Medicare & Secure Horizons
Health Net	21600 Oxnard Street Woodland Hills, CA 91367	(800) 522-0088 – Non-Medicare (800) 596-6565 – Seniority Plus
Health Plan of Nevada	3320 West Sahara Avenue Suite 300 Las Vegas, NV 89114	(800) 777-1840 – Non-Medicare (800) 650-6232 – Retiree Choice
Hometown Health	400 South Wells Avenue Reno, NV 89502	(800) 336-0123 – Non-Medicare Plan

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

Dear Retired Member:

This booklet is specifically designed for retired members and their eligible dependents who live within a geographical area serviced by one or more of the HMOs offered through the Trust. To confirm that you live within an HMO service area you should contact the Administrative Office at the telephone number above.

The Trust's coverage options for retired members who live in an HMO service area consist of a number of HMO plans, some designed specifically for those enrolled in Medicare and others designed for those not yet eligible to enroll in Medicare. The number and type of HMO plans from which you can choose will vary depending on where you live. Summaries of all the options are contained in the inside front pocket of this booklet. Please remember though, that not all of the HMO options will be available to you – those available to you will depend on where you live.

Once you have enrolled in one of the Trust's HMO options you should refer to the Evidence of Coverage/Disclosure booklet issued by the HMO to determine your benefits and how to use the program. We urge you to keep that booklet in the front or back pocket of this booklet for ease of reference. You should refer to this booklet, which is issued directly by the Trust, for the eligibility rules and general provisions which apply to all health coverages offered to retired sheet metal workers and their eligible dependents.

If you have any questions about eligibility or benefits please refer to page 2 of this booklet for the addresses and telephone numbers you should use to get the answers you are seeking.

Sincerely,

Board of Trustees

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Please refer to your HMO Evidence of Coverage/Disclosure booklet for your health benefits, how to obtain services and supplies, and claims and appeals procedures.

DEFINITIONS

Listed below are definitions of some of the terms used in this booklet.

Board of Trustees means the Board of Trustees referred to in the Trust Agreement which establishes this Plan.

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.

HMO means Health Maintenance Organization.

Non-Covered Sheet Metal Service means sheet metal work in the geographical jurisdiction of the Plan or a related plan 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 Plan or a related plan. It includes all work or services of the kind performed by any Contributing Employer to the Plan which relates in any way to any work of the kind performed by participating employees covered by the 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.

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

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.

Plan means the health plans designated as Retiree Plans provided by the Sheet Metal Workers' Health Plan of Southern California, Arizona and Nevada. Plan also means the Sheet Metal Workers' Health Plan of Southern California, Arizona and Nevada.

Qualified Medical Child Support Order (QMCSO) is, according to federal law, a child support order of a court or state administrative agency that usually results from a divorce or legal separation, that has been received by the Trust, and that meets all of the following requirements.

- Designates one parent to pay for a child's health plan coverage.
- Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO.
- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is to be determined.
- States the period for which the QMCSO applies.
- Identifies each health care plan to which the QMCSO applies.

DEFINITIONS (continued)

An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any option that the Plan does not otherwise provide, or if it requires an employee or retiree who is not covered by the Plan to provide coverage for a Dependent child, except as required by a State's Medicaid-related child support laws. For a State administrative agency order to be a QMCSO, State statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by State law. An order is not a QMCSO unless it is approved and recognized by the Plan as a QMCSO.

Sheet Metal Industry means all work or services of the kind performed by any Contributing Employer to the Pension Plan 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 manufactures, 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 (other than continued employment in a job capacity he/she continuously performed prior to your retirement,) 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;
- 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.

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

You (or you) means a retired sheet metal worker, dependent or other individual who meets the eligibility requirements for coverage under the Plan.

ELIGIBILITY RULES FOR COVERAGE

GENERAL

One or more of the following benefit plans are offered to participants who reside within an HMO service area. Only specified Zip Codes within California, Nevada and Arizona are included in the HMO service areas. To determine if you reside within an HMO service area and which HMOs are available to you, contact the Administrative Office at (800) 947-4338.

If you do not reside within any of the HMO service areas, no coverage is offered to you by the Trust unless you retired prior to January 1, 2003, and as of December 31, 2002, you did not reside in any of the HMO service areas. If you think you fall into this category please contact the Administrative Office for details on the coverages that may be available to you.

HMO Offerings as of January 1, 2003

Please note that from time to time the HMOs offered by the Trust may change and the service areas covered by the HMOs may change. You should refer to the Summary of HMO Plans periodically issued by the Administrative Office for an up-to-date summary of the HMOs offered by the Trust, or, contact the Administrative Office.

	California	Nevada	Arizona
If you **are** eligible for Medicare and you **are** enrolled in Medicare Parts A and B →	PacifiCare's Secure Horizons	PacifiCare's Secure Horizons (Southern Nevada Only)	PacifiCare's Secure Horizons
→	Kaiser's Senior Advantage	Health Plan of Nevada's Retiree Choice Plus	
→	Health Net's Seniority Plus		
If you **are not** eligible for Medicare →	PacifiCare	PacifiCare (Southern Nevada Only)	PacifiCare
→	Kaiser	Health Plan of Nevada	
→	Health Net	Hometown Health Plan	

Please note that benefits differ by State and whether or not you are enrolled in Medicare. The health plan options available to those eligible for Medicare are only available if you are enrolled in both Part A and Part B of Medicare and you assign your Medicare benefits to the HMO.

ELIGIBILITY RULES FOR COVERAGE (continued)

Open Enrollment

Participants elect their health plan option at the time they first become eligible and may change their election only during an annual open enrollment period designated by the Plan unless they move their primary residence outside their selected plan's service area or their selected HMO no longer offers coverage in their area. If you plan on moving outside your HMO's service area notify the Administrative Office immediately. You may be able to enroll in another HMO offered by the Trust if your new residence is in another HMO's service area. Please note however, that if no contracted HMOs are available to you in your area, you will not have any coverage from the Trust.

Shortly before each annual open enrollment period, the Administrative Office will send you information on the health plan options that may be available to you (depending on your Zip Code). You then have a specific period of time to decide if you want to change options and complete and mail your change to the Administrative Office. If you do not submit a new election by the end of the designated open enrollment period, you will retain the same health plan option you had immediately prior to the annual open enrollment period.

If a participant also wants coverage for his eligible dependents, the eligible dependents must be enrolled in the same HMO option as the participant. However, the HMO's benefit plan will differ for the participant and the eligible dependent if one is enrolled in Medicare Part A and B and the other is not eligible for Medicare. Refer to the comparison of health care options in the front pocket of this booklet for a description of the Medicare and non-Medicare benefits.

WHO IS ELIGIBLE

Retired employees who are receiving a Pension Benefit and reside within an applicable HMO service area are eligible to elect and pay for coverage except as provided below.

Exceptions:

- 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.)

ELIGIBILITY RULES FOR COVERAGE (continued)

- ➢ 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 suspendible employment in the terms of the Pension Plan because he is working in the Sheet Metal Industry in violation of the Pension Plan (without notifying the Pension Plan) is not eligible for retiree health coverage during the period of such work.
- ➢ A person who elected to be covered under the Trust's active plan COBRA coverage at the time retiree health benefits were initially offered to the person (or on whose behalf such an election was made) is not eligible for retiree health coverage even after COBRA coverage terminates (except under the Plan's Special Enrollment provisions, see page 12 and 13).

Any premiums paid on behalf of participants and/or their dependents during any period of ineligibility must be repaid to the Trust by the participant and/or dependent including attorney's fees, interest, and reasonable collection costs. The Trust 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. The participant and/or dependent may also be required to reimburse the Trust and/or the HMO for the value of any HMO benefits provided to the participant and/or his dependents while ineligible.

Eligible Dependents

Participants or surviving spouses who enroll in this Plan may also enroll their dependents if such dependents meet the rules below and all the required documentation of dependent status is filed with the Administrative Office in a timely manner. Note however, that enrollment in this Plan is not permitted if the Trust's active plan COBRA coverage is elected by the dependent or on behalf of the dependent at the time retiree health plan coverage is initially offered to the participant or surviving spouse.

Eligible dependents include the participant's:

- legal spouse (former spouses are not eligible after the effective date of the dissolution of marriage or final divorce decree);
- unmarried children but only under the following two instances:
  - ➢ if the participant met the requirements of a Disability Pension Benefit (as defined in the Pension Plan) as of the date of his retirement, or
  - ➢ if the child was totally prevented from earning a living because of a mental or physical disability, and
    - i) was so disabled and covered under the retiree health Plan on June 30, 1988, or
    - ii) if he was so disabled and covered under the active health plan provided by the Trust immediately prior to the transfer of coverage to the retiree health Plan.

  In such cases, proof of the child's continued disability must be submitted to the Administrative Office annually.

ELIGIBILITY RULES FOR COVERAGE (continued)

If one of the above two instances apply, the following additional requirements must be met in order for unmarried children to be eligible for enrollment:

Age Requirement -

- the children must be under 19 years of age, or
- the children must be between the ages of 19 and 23 and enrolled as a full time student (at least 12 units per semester or quarter) in an accredited institution of learning, (note that coverage is provided during the summer break if the child is under 23 years of age and was in school immediately prior to the summer break and is enrolled for the following semester or quarter), or
- at any age if the unmarried child is disabled as described above.

Dependency Status -

- disabled children age 19 or over must be **solely** dependent upon the participant or the participant's surviving spouse for support; students between the ages of 19 and 23 years must be primarily dependent upon the participant or the participant's surviving spouse for support, and
- the children must be the participant's natural children, legally-adopted children, children placed for adoption if under 18 years old, step children, or any other children for whom, by a Qualified Medical Child Support Order, the participant is legally responsible for the child's health care expenses. A child is "placed for adoption" on the date the participant first becomes legally obligated to provide full or partial support of the child whom the participant plans to adopt.

In no event will a spouse or child be covered simultaneously as a dependent and as a participant under this Plan or any other plan provided by the Trust nor shall a spouse or child be covered simultaneously as a dependent of more than one participant under this Plan or any other plan provided by the Trust.

In order to establish eligibility for your dependents, certain documents must be provided to the Administrative Office at the time you enroll the dependents. Contact the Administrative Office for details on the documentation that is required to be submitted.

→ *IMPORTANT* ←

You must IMMEDIATELY notify the Administrative Office in writing when changes in dependency status occur. This includes final dissolution of marriage, annulment, death, a former student over 19 not taking enough units at school, marriage of a child, or any other event that would make a dependent not eligible for further coverage.

ELIGIBILITY RULES FOR COVERAGE (continued)

If you do not immediately notify the Administrative Office and premiums are paid on behalf of an ineligible dependent, the participant and/or the dependent is responsible for reimbursing the Trust for such premiums, including attorney's fees, interest and reasonable collection costs. The Trust 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. The participant and/or dependent may also be required to reimburse the Trust and/or the HMO for the value of any HMO benefits provided to the ineligible dependent.

Special Provision for Surviving Spouses

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

When death occurs prior to enrollment in this Plan

Surviving spouses (and their eligible dependent children – refer to page 9) of deceased sheet metal workers may enroll in the retiree health Plan if the following conditions are met:

- as of the date of the sheet metal worker's death, he was entitled to a Pre-Retirement Pension Benefit (as defined in the Pension Plan), and
- as of the date of the sheet metal workers death, he was covered under a health plan provided by the Trust, and
- the surviving spouse does not remarry.

Please note that the Plan's provisions regarding work in Non-Covered Sheet Metal Service as explained on page 8 also apply to this special surviving spouse provision. The work histories of both the surviving spouse and the deceased sheet metal worker will be reviewed individually when determining if the surviving spouse (and dependent children) are eligible to enroll.

When death occurs while enrolled in this Plan

If a retired sheet metal worker dies while he is a participant and covered under this Plan, his surviving spouse (and eligible dependent children) who are covered under this Plan as of the date of death, may continue coverage by making the required self-payments as discussed later in this booklet.

WHEN AND HOW TO ENROLL IN COVERAGE

Participants are given the opportunity to enroll at the time they apply for Pension Benefits. The Administrative Office will provide you with the necessary paperwork and a description of your health care options. If you do not enroll yourself and your eligible dependents (or can not enroll because you do not live within a contracted HMO service area) when you apply for your Pension Benefits, you will have a one time opportunity to enroll at a later date, **BUT YOU MAY HAVE TO PAY MORE FOR YOUR COVERAGE – REFER TO THE SPECIAL ENROLLMENT PROVISION ON THE NEXT PAGE.**

ELIGIBILITY RULES FOR COVERAGE (continued)

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 9 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 unless they meet the requirements described under the Special Enrollment provision below.

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.

Special Enrollment

Under current Plan rules (which are subject to change or elimination at any time), if a participant or surviving spouse does not enroll himself and/or his dependents when first entitled to do so, or, is unable to enroll because he resides outside any of the Trust's contracted HMO service areas, such participant or surviving spouse may enroll at a later date based on the following rules. **AS NOTED BELOW, YOUR SELF-PAY CONTRIBUTION MAY BE SIGNIFICANTLY HIGHER UNDER CERTAIN CIRCUMSTANCES IF YOU DO NOT ENROLL WHEN FIRST ENTITLED TO DO SO.**

➢ ***If you had other group coverage***

If you or your dependent, as appropriate, were covered under another group health plan or had health insurance coverage at the time you previously declined coverage under this Plan, you may still be eligible to enroll if all of the following conditions are met:

- at the time you or your dependent, as appropriate, declined coverage under this Plan, you provided written confirmation to the Administrative Office that coverage under another group health plan or health insurance program was the reason you declined coverage under this Plan (if the Administrative Office requested such confirmation); and
- you or your dependent's, as appropriate, prior coverage was terminated due to the loss of eligibility for coverage or the employer ceased making contributions for said coverage; and
- you submit a completed enrollment form for coverage under this Plan and any other requested documentation within 30 days after the date coverage is lost under the other plan; and
- you reside in a contracted HMO service area.

If these conditions are met and you meet the eligibility rules for this Plan, your coverage will begin as of the date the other coverage terminates. If you enroll under these circumstances your self-pay contribution will be the same as if you had enrolled when first eligible to do so.

➢ ***If you did not live in a contracted HMO service area***

If your initial enrollment for coverage under this Plan was disallowed because you did not live within a contracted HMO service area and you later move to an area in which contracted HMO coverage is available or a contracted HMO expands its service area to include where you live, you may enroll in whichever HMO is available to you, provided you submit the necessary enrollment form and any other requested documentation to the Administrative Office within 31 days from the date you relocate or the date HMO coverage is otherwise available to you. Your coverage will begin the first day of the month following the date the Administrative Office receives your completed enrollment form and other requested documentation. If you enroll under these circumstances your self-pay contribution will be the same as what you would pay had you initially lived in an HMO service area.

➢ ***For any other reason***

If you do not fall into either of the above categories, you nevertheless have a one time opportunity to enroll in this Plan after your initial enrollment date if you meet the eligibility rules for coverage under this Plan (as described on pages 8 and 9) and you reside in a contracted HMO service area at the time application is made for coverage under this provision. It is up to you to decide when you want to enroll under this "one time opportunity" provision. You must complete and submit an enrollment form to the Administrative Office along with any requested documentation. Your coverage will begin on the first day of the month following the date the Administrative Office receives your enrollment form and any requested documentation. **IF YOU ENROLL UNDER THESE CIRCUMSTANCES YOUR SELF-PAY CONTRIBUTION MAY BE SIGNIFICANTLY HIGHER THAN IT WOULD BE IF YOU HAD ENROLLED WHEN YOU WERE FIRST ELIGIBLE TO DO SO.**

If you want to enroll under these special enrollment provisions, contact the Administrative Office for enrollment materials and a description of the health care options available to you.

SELF-PAY CONTRIBUTION REQUIREMENT

Participants and surviving spouses must contribute towards the cost of their health care coverage under this Plan. The monthly self-pay contribution rates are determined and periodically changed 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.

ELIGIBILITY RULES FOR COVERAGE (continued)

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 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 Trust. **ONCE TERMINATED UNDER THESE CIRCUMSTANCES, COVERAGE CANNOT BE REINSTATED NOR CAN YOU RE-ENROLL IN THE 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.

EFFECTIVE DATE OF COVERAGE

A participant who enrolls under this Plan at the time of his application for Pension Benefits will become covered under his selected HMO plan on the later of the following dates, provided all enrollment and self-pay contribution requirements are met:

- the date his Pension Benefits commence,
- the date his eligibility under the Trust's active plan terminates, or
- the date his eligibility under the Arizona Sheet Metal Workers' Health Plan terminates.

A surviving spouse who enrolls under this Plan when first entitled to do so as outlined under Special Provision for Surviving Spouses, will become covered under her selected HMO plan on the later of the following dates that are applicable to her, 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 Trust's active plan terminates, or
- the date her eligibility under the Arizona Sheet Metal Workers' Health Plan terminates.

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 is elected and the dependent is listed on the enrollment form, such dependent will become covered under the HMO plan selected by the participant or surviving spouse on the date coverage is effective for the participant or surviving spouse, provided all requested documentation is submitted on a timely basis and the required self-pay contribution is made for the dependent.

ELIGIBILITY RULES FOR COVERAGE (continued)

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 (if you are eligible to enroll dependent children, a newborn child is covered from birth provided you submit an enrollment form for the child within 31 days following birth),
- for those enrolling under the Special Enrollment provision, on the applicable date set forth in that provision.

TERMINATION DATE OF COVERAGE

Coverage for a participant or surviving spouse enrolled in this 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 suspendible 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 participant or surviving spouse to terminate coverage. If the 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 date coverage for the participant or surviving spouse is terminated by an HMO for cause (as defined in the service agreement between the Trust and the HMO) unless another HMO is available to the participant or surviving spouse and such individual enrolls in the other HMO within 31 days following the date coverage would otherwise terminate,
- the first day of the month following the date the participant or surviving spouse no longer resides in his/her selected HMO service area unless another HMO is available to the participant or surviving spouse and such individual enrolls in the other HMO within 31 days following the date coverage would otherwise terminate,
- for those enrolled in Medicare and covered under a Medicare + Choice plan offered by the Trust, the date such individual is no longer enrolled in Medicare Part A and Part B,
- for those enrolled in Medicare and covered under a Medicare + Choice plan offered by the Trust, the date the participant's or surviving spouse's Medicare assignment of benefits to the HMO under which he/she is enrolled, is no longer valid,
- for those who become eligible to enroll in Medicare but fail to enroll in either or both Part A and Part B of Medicare, the date Medicare coverage would have been effective had the individual enrolled when first eligible to do so,
- the date this 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 participants or surviving spouses in which the participant or surviving spouse belong,
- the date of entrance into full-time military service with the Armed Forces of the United States,
- 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 participant's or surviving spouse's coverage terminates for reasons other than the death of the participant. In the event of the death of the participant, dependents may continue coverage in accordance with the Special Provision for Surviving Spouses (page 11),
- the first day of the month following the date the dependent no longer meets this Plan's eligibility requirements for dependents,
- the date coverage for the dependent is terminated by an HMO for cause (as defined in the service agreement between the Trust and the HMO) unless another HMO is available to the participant or surviving spouse upon whose eligibility the dependent's coverage is based and such participant or surviving spouse enrolls in another HMO within 31 days following the date coverage would otherwise terminate,
- for those enrolled in Medicare and covered under a Medicare + Choice plan offered by the Trust, the date such individual is no longer enrolled in Medicare Part A and Part B,
- for those enrolled in Medicare and covered by a Medicare + Choice plan offered by the Trust, the date the dependent's Medicare assignment of benefits to the HMO, under which he/she is enrolled, is no longer valid,
- for those who become eligible to enroll in Medicare but fail to enroll in either or both Part A and Part B of Medicare, the date Medicare coverage would have been effective had the individual enrolled when first eligible to do so,
- the date this 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,
- the first day of the month following the date the dependent worked two calendar quarters in Non-Covered Sheet Metal Service.

CERTIFICATE OF COVERAGE

When a participant's coverage terminates, he will receive a "Certificate of Coverage." The certificate provides information regarding the period of coverage under this Plan. This information may be used to reduce or eliminate a pre-existing condition limitation period under a new group health plan, under which the participant becomes covered. A participant may also request a copy of the certificate at any time within 24 months after coverage terminates. If a dependent loses eligibility separately and the Administrative Office is notified that the dependent is no longer eligible, a separate certificate will be provided for that former dependent; this certificate may also be requested within 24 months after the dependent's coverage has been terminated.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

If a court or state administrative agency has issued an order with respect to health care coverage for any dependent child of the participant, a copy of the order should be promptly mailed to the Administrative Office. The Administrator or its designee will determine if that order is a QMCSO. That determination will be binding on the participant, the other parent, the child, and any other party acting on behalf of the child. The Administrator or its designee will notify the parents and each child if an order is determined to be a QMCSO, and if the participant is covered by the Plan and if such participant is entitled to coverage for dependent children and advise them of the procedures to be followed to provide coverage of the dependent child(ren).

If the participant is covered under this Plan and is entitled to coverage for dependent child(ren) in accordance with the eligibility rules set forth in this Plan, the QMCSO may require this Plan to provide coverage for the participant's dependent child(ren) and to accept any required self-pay contributions for that coverage from a parent who is not a participant in this Plan. This Plan will accept a special enrollment of the dependent child(ren) specified by the QMCSO from either the participant or the custodial parent. Coverage of the dependent child(ren) will become effective as of the date the enrollment is received by the Administrative Office, and will be subject to all terms and provisions of this Plan.

If the participant is not enrolled in this Plan at the time the QMCSO is received, the Administrator will return the documents to the sender and notify all interested parties that coverage under this Plan is not available to the dependent child(ren) until such time the participant becomes covered under this Plan. Similarly, if the participant is not entitled to coverage of his dependent child(ren) in accordance with the eligibility rules set forth in this Plan, the Administrator will return the documents to the sender and notify all interested parties that coverage under this Plan is not available to the dependent child(ren).

No coverage will be provided for any dependent child under a QMCSO unless any applicable participant self-pay contributions for that dependent child's coverage are paid, and all of this Plan's requirements for coverage of that dependent child have been satisfied.

COBRA COVERAGE

Retiring sheet metal workers or surviving family members who qualify for enrollment in the Trust's retiree health plan may either elect to extend active health benefits under the COBRA coverage provided under the active plan or retiree health plan benefits. If active plan COBRA coverage is chosen, anyone who is enrolled in that coverage cannot enroll in this Plan or any other retiree health plan provided by the Trust, even after active plan COBRA coverage terminates. By electing active plan COBRA coverage, you give up all entitlement to enroll in any retiree health plans provided by or through the Trust. (Note: An exception currently exists under the Plan's Special Enrollment provisions, see pages 12 and 13.) For details on active plan COBRA coverage, refer to the active plan benefit booklet.

This Plan also has a COBRA coverage extension, but only for dependents of retired sheet metal workers (not the retired sheet metal workers) who are covered under this Plan as dependents and whose coverage is terminating because of one of the following qualifying events:

ELIGIBILITY RULES FOR COVERAGE (continued)

- divorce of the participant from the participant's spouse,
- a dependent child ceases to meet the qualifications of an eligible dependent under this Plan.

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, it cannot be reinstated.

Notification Requirements

In order to be eligible to elect COBRA coverage, the participant or dependent must notify the Administrative Office in writing of divorce or a child losing dependent status as soon as possible but not later than 60 days after the later of:

- the date the event occurred, or
- the date Plan coverage would be lost as a result of the event.

After the dependent is notified of his 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:

- the date Plan coverage would be lost, or
- the date the dependent was notified of the right to elect COBRA coverage.

Each dependent has an independent right to elect COBRA coverage.

Type of Coverage

COBRA coverage consists of the same health care benefits provided to similarly situated dependents for whom a qualifying event has not occurred.

Cost and Payment of COBRA Coverage

COBRA coverage requires monthly self-payments from you. The self-payment amount is based on the Trust's costs to provide coverage to retirees and their dependents for whom a qualifying event has not occurred. 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 you 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. Payments must be made by personal check or money order.

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

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 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, 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

You may continue your COBRA coverage for a maximum of 36 months even if another qualifying event occurs while you are enrolled in COBRA.

COBRA coverage begins on the date regular coverage under the Plan terminates and will be extended for 36 months. However, COBRA coverage will terminate earlier if any of the following events occur prior to the expiration of the 36-month period:

- termination of this Plan,
- failure to pay the required premium on a timely basis,
- you become covered, after your COBRA election date, under another group health plan which does not contain any exclusion or limitation with respect to any pre-existing health condition you have,
- you become enrolled in Medicare after your COBRA election date,
- you perform 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 documentation and payment of the applicable self-payment rate within 31 days from the date of marriage. Refer to page 12 on how to enroll newly acquired dependents.

If the new spouse is not enrolled within 31 days of the marriage because he or she was covered under another group health plan or other health insurance coverage and that coverage terminates for any of the reasons noted below, the spouse can be enrolled under the COBRA beneficiary's coverage option for the balance of the COBRA beneficiary's extension period, if enrollment occurs within 31 days after the termination of the other coverage.

ELIGIBILITY RULES FOR COVERAGE (continued)

Termination of the other coverage must be due to:

- exhaustion of COBRA coverage under the other plan,
- loss of eligibility, or
- termination of employer contribution toward the other coverage.

Termination due to failure of the spouse to pay premiums on a timely basis or for cause does **not** qualify under these rules.

MEDICARE INFORMATION

Medicare benefits are available to people age 65 or older, people who have been on Social Security disability benefits continuously for two years and people with end stage renal disease. It is important that you enroll promptly in this extensive program of health insurance.

YOUR COVERAGE UNDER THE TRUST WILL TERMINATE WHEN YOU BECOME ELIGIBLE FOR MEDICARE UNLESS YOU HAVE ENROLLED IN MEDICARE PART A AND PART B AND ASSIGN YOUR MEDICARE BENEFITS TO THE HMO PLAN UNDER WHICH YOU ARE COVERED.

To apply for Medicare, call or write your nearest Social Security office at least 90 days prior to your 65th birthday and ask for a Medicare 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.

Regarding the assignment or reassignment of your Medicare benefits to an HMO offered by the Trust, please note the following:

- You may only assign your Medicare benefits to one health care plan at a time;
- To terminate your assignment, you must complete and submit a special form available from the HMO or the Administrative Office. The completed form should be submitted to the Administrative Office. You will need to submit the special termination form if, for example, you are terminating your HMO coverage through the Trust and are replacing it with a Medicare supplement plan. If you are changing from one HMO to another, you do **not** have to submit the special termination form (refer to the next arrow).
- If you need to reassign your Medicare benefits, for example, when you are changing from one HMO to another during the Trust's annual open enrollment, do **not** submit the special termination form referred to above. When you submit the completed enrollment form for the HMO plan you are transferring to, your Medicare benefits are then reassigned to that HMO.

You are urged to contact the Administrative Office if you have any questions regarding the assignment of your Medicare benefits.

DISCLAIMERS

- All of the HMO benefits offered through the Trust are insured by the respective HMOs. The Board of Trustees has no obligation to provide any benefit other than payment of monthly premiums due in accordance with the service agreements between the Trust and the HMOs.

- The only sources of authorized information are the benefit booklets and booklet inserts, if any, the Trust Agreement, the Service Agreements between the HMOs and the Trust, the written statements of the Trust Administrative Office on behalf of the Plan, and the written statements of duly authorized representatives of the HMOs with respect to benefits and coverage under the HMOs.

- Your rights with respect to eligibility under the Trust are determined by the Plan's eligibility provisions set forth in this booklet and booklet inserts, if any. Your rights with respect to benefits provided by an HMO are determined by the Service Agreement between the Trust and the HMO. In the event of any conflict between the provisions contained in the Service Agreements with the HMOs 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 Trust. In the event the Trust is terminated by the Board of Trustees, the rights of all participants covered under the Trust 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 and 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 or services which have already accrued,
  - to terminate this Plan and/or any other health coverage offered through the Trust even though such termination affects claims or services 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 health plan options, the Administrative staff can only describe Plan options and verify eligibility, in general, based upon information provided, thus far, and subject to all terms of the Plan. Verification does not guarantee or validate eligibility or your health plan options.

- The Trust, Board of Trustees or any of their designees are not 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 Trust, Board of Trustees, nor any of their designees, will have any liability whatsoever for any loss or injury caused to a Trust participant or beneficiary by any health care provider by reason of negligence, by failure to provide care or treatment, or otherwise.

CLAIMS AND APPEALS PROCEDURES

The following provisions apply only to claims or appeals that pertain to eligibility for benefits under the Trust. Different claims and appeals procedures apply to health care benefits, treatments or supplies. For those procedures, please refer to the Evidence of Coverage/Disclosure booklet issued by your HMO. Remember: claims or appeals pertaining to benefits must be directed to your HMO. These claims and appeals procedures apply **only** to Plan eligibility issues.

When a claim for eligibility (a "claim") is submitted to the Administrative Office, it is identified as a pre-service, urgent care, post-service, or concurrent care claim.

A "pre-service" claim is a claim for eligibility for a benefit for which the HMO requires approval before medical care is obtained.

An "urgent care" claim is a pre-service claim for eligibility for benefits 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.

A "concurrent care" claim is a claim for eligibility for benefits that is reconsidered after an initial approval was made and results in a reduced or terminated benefit. (An example would be an inpatient hospital stay originally certified for five days that is reviewed at three days to determine if the full five days is appropriate.)

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

An initial determination on urgent care claims will be made by the Administrative Office within 72 hours from receipt of the claim. If the Plan 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 Administrative Office 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 Administrative Office 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.

A reconsideration of eligibility for a benefit with respect to a concurrent care claim will be made by the Administrative Office as soon as possible, but in any event early enough to allow the claimant to have an appeal decided before eligibility for the benefit is reduced or terminated. Any request by a claimant to extend eligibility for an approved urgent care treatment will be acted upon by the Administrative Office within 24 hours of receipt of the request, provided the request is received at least 24 hours prior to the expiration of the approved treatment. If the request involving urgent care is received less than 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 Administrative Office, 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). The initial determination will include detailed information concerning the basis for the decision and your appeal rights.

If you receive from the Administrative Office an answer to an eligibility claim with which you disagree, you or a duly authorized representative of your choice may request a review of the decision. The request for review must be in writing and submitted to the Administrative Office (with the exception of urgent care appeals, which may be oral). The request for review must be received by the Administrative Office 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. 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.

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 of Trustees. The Eligibility Committee will independently consider all comments, documents, records and other information submitted by you or your authorized representative relating to the eligibility 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 appeals procedures.

CLAIMS AND APPEALS PROCEDURES (continued)

This written explanation of the Eligibility Committee's decision will be provided to you within 72 hours from 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 composed 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 a written explanation giving detailed reasons for any denial; specific reference to pertinent Plan provisions or documents on which the decision is based; a statement of your right 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.

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

The decision of the Appeals Committee shall 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.

CLAIMS AND APPEALS PROCEDURES (continued)

This appeals procedure for eligibility shall be the sole and exclusive procedure available to an individual who is dissatisfied with an 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.

GENERAL PROVISIONS

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 necessary factual determinations regarding eligibility for benefits or any other issue regarding the Plan.

WORKER'S COMPENSATION NOT AFFECTED

The benefits provided by this 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, and, in the event of any conflict between the provisions contained in this booklet 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 sole purpose of determining eligibility 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 Trust's Administrative Office deems to be necessary for such purposes. Any participant claiming benefits under the Plan must furnish to the Trust's Administrative Office all such information as may be necessary to implement this provision.

RIGHT OF RECOVERY

Whenever premiums are paid by the Trust on behalf of an ineligible participant or dependent, the Trust shall have the right to recover such premiums, including attorney's fees, interest and reasonable collection costs and, in some cases, the value of any benefits provided, during the period of ineligibility, 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, or
- any other plan.

DELINQUENT OWNER-PARTICIPANTS

If a participant or his spouse has an ownership or management interest in an employer that contributed on his behalf, no premiums will be paid, no benefits will be provided, and no COBRA continuation coverage will be available, for that individual or his 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.

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 and for the ease 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.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. This covers reconstruction of the breast on which the mastectomy was performed, surgery on the other breast to produce a symmetrical appearance, and prosthesis and physical complications of all stages of mastectomy, including lymphedemas. This Plan complies with this requirement.

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

NAME OF PLAN: This 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 beneficiaries who reside in a contracted HMO service area.

PLAN SPONSOR AND ADMINISTRATOR: The Board of Trustees is both the Plan Sponsor and the 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.

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 Plan number is 501.

AGENT FOR SERVICE OF LEGAL PROCESS: The name and address of the agent designated for the service of legal process is:

Richard Wondra, Administrator
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 Sheet Metal Workers' International Association, local unions and employers in the industry and/or in accordance with participation agreements between such employer and the Trust.

SOURCE OF CONTRIBUTIONS: The benefits described for participants 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.

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (continued)

TYPE OF PLAN: The Retiree Plans are maintained for the purpose of providing hospital, medical and prescription drug benefits in the event of sickness or injury.

TRUST FUND: All assets are held in trust by the Board of Trustees 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: The Plan described in this booklet provides HMO benefits only. Premiums are paid to the HMOs on behalf of participants and dependents who have elected coverage under this Plan. In turn, the HMOs fully insure the benefits provided by them.

The HMOs are listed on page 2 of this booklet. These HMOs pay claims and handle claim appeals related to their programs of benefits. These HMOs will supply you, upon written request, written materials concerning the nature of services provided, conditions pertaining to eligibility to receive such services (other than general conditions pertaining to eligibility for participation in the Trust) and circumstances under which such services may be denied, the procedures to be followed in obtaining such services, and the procedures available for the review of claims for services which are denied in whole or in part. Requests for such materials may be addressed to the Plan Administrator at the address given in "Plan Sponsor and Administrator" on page 29.

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 PLAN'S REQUIREMENTS WITH RESPECT TO ELIGIBILITY FOR PARTICIPATION AND BENEFITS: The eligibility requirements are specified on pages 7 through 20.

CIRCUMSTANCES RESULTING IN DISQUALIFICATION, INELIGIBILITY OR DENIAL OR LOSS OF BENEFITS: Loss of eligibility is described on pages 7 through 20.

CLAIMS FILING AND CLAIMS APPEAL PROCEDURES: Claims filing and claims appeal procedures are described in the Evidence of Coverage/Disclosure booklets issued by the HMOs. Claims and appeals involving issues of eligibility for benefits under the Plan are described on pages 23 through 26.

STATEMENT OF ERISA RIGHTS: Participants in the Sheet Metal Workers' Health Plan of Southern California, Arizona and Nevada, are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

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

Continue Group Health Coverage

Continue health care coverage for your spouse and dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage and when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

STATEMENT OF RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (continued)

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

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.

Nothing in the foregoing statement is meant to interpret or extend or change in any way the provisions expressed in the Plan. The Board of Trustees reserves the right to amend, modify, rescind, or discontinue all or a part of this Plan at any time and for any reason, in its sole and absolute discretion in accordance with procedures specified in the Trust Agreement.

MEMBERS OF THE BOARD OF TRUSTEES

The Board of Trustees is responsible for the operation of the Plan. The Board of Trustees consists of employer and union representatives, selected by the employers and unions in accordance with the Trust Agreement which relates to the Plan. If you want 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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