

Sheet Metal Workers Local 88 Retiree Health Reimbursement Plan

Summary Plan Description

October 1, 2009



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P.O. Box 10067
Manhattan Beach, CA 90266
(800) 947-4338
Fax: (310) 798-0766

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Retiree Health Reimbursement Plan

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Dear Retiree,

We are proud to present your new Summary Plan Description for the Sheet Metal Workers Local 88 Retiree Health Reimbursement Plan, (“Plan”) describing benefits available from the Plan as of October 1, 2009. (The Plan was formerly called the Sheet Metal Workers Local 88 Retiree Health Plan). We urge you to read this booklet carefully so that you understand the valuable benefits provided under this Plan.

In reviewing this booklet, please keep in mind that for claims before October 2009, the provisions of the Plan in effect on the date the claim arose will be applied. The earlier Plan provisions may be different from the current Plan rules.. And please note that this booklet is merely a summary of the rules and regulations of the Plan. Your benefits are calculated and otherwise governed by the Plan document (the “Rules and Regulations” of the Plan), as amended by the Board of Trustees from time to time. A copy of the Plan document can be obtained from the Administrative Office at the address shown above.

The Board of Trustees has full discretion and authority to interpret the Plan rules and regulations and to decide any question regarding the nature and extent of benefits provided under the Plan. The Trustees also have full discretion and authority to decide any factual question related to eligibility and benefits provided by the Plan.

For your protection, only the full Board of Trustees is authorized to interpret the Plan. While every effort is made by the Union (Sheet Metal Workers Local 88) and employers participating in the Plan to help you obtain correct information about the Plan, information you receive from the Union, employers participating in the Plan, or their representatives, is unofficial and nonbinding on the Plan. In order to be official, any information or opinion about your rights under the Plan must be communicated to you by the Administrative Office in writing and signed on behalf of the Board of Trustees.

Please remember to keep the Administrative Office informed of any change in your mailing address to ensure that you receive all communications. Any questions about your benefits or your rights and responsibilities should be directed to the Administrative Office at the above address.

Sincerely,

BOARD OF TRUSTEES

Sheet Metal Workers Local 88 Retiree Health Reimbursement Plan

Summary Plan Description

WHAT BENEFITS DOES THE PLAN PROVIDE?

The Sheet Metal Workers Local 88 Retiree Health Reimbursement Plan reimburses eligible participants for health care premiums and expenses as follows::

- The Plan reimburses eligible retirees for premiums they have paid for qualifying medical, dental and vision insurance coverage for themselves and their “eligible dependents” (as defined by the Plan), up to the maximum allowable benefit determined by the Trustees. The Plan will reimburse premiums you pay for Medicare coverage, monthly premiums you are paying for retiree health coverage to the Sheet Metal Workers’ Health Plan of Southern California, Arizona and Nevada (“Health Plan”), and premiums for any **individual** health, dental and vision insurance policies that you purchased from insurers such as Humana, United Health Care, Sierra Health Services, Delta Dental and Vision Service Plan.
- The Plan reimburses a maximum of \$2,000 per family for eligible out-of-pocket dental, vision and hearing aid expenses for participants and their eligible dependents. Reimbursement is limited to amounts paid for services performed (for example, optometry exams) and eligible items purchased (for example, glasses, dentures, and hearing aids) during the calendar year.

Please note: Benefits paid by the Plan are tax free to the recipient in accordance with applicable federal law and regulations and Internal Revenue Service rules governing Health Reimbursement Arrangements (HRAs), of which the Plan is one.

WHO IS ELIGIBLE?

All members of Sheet Metal Workers Local 88 (that is, those paying at least “Minimum Dues”) who have been awarded a pension from the Sheet Metal Workers’ Pension Plan of Southern California, Arizona and Nevada (“Pension Plan”), and have been receiving a monthly pension benefit from the Pension Plan for at least six months are eligible for benefits, provided that the member either:

1. Retired before January 1, 2007 and worked at least 2,700 hours under a Local 88 collective bargaining agreement in the five years before the effective date of pension benefits from the Pension Plan, **or**
2. Retired on or after January 1, 2007 and before January 1, 2009, and worked at least 1,300 hours under a Local 88 collective bargaining agreement in each of the five years before the effective date of pension benefits from the Pension Plan, or maintained membership

in Local 88 for at least the ten years before retirement and the effective date of pension benefits from the Pension Plan, **or**

- 3.. Retired on or after January 1, 2009 and (a) worked at least 1,350 hours under a Local 88 collective bargaining agreement in any five of the ten years before retirement and the effective date of pension benefits from the Pension Plan, and maintained membership in Local 88 for at least ten years before retirement and the effective date of pension benefits from the Pension Plan, **or** (b) earned at least seven years of credited service in the Pension Plan under a Local 88 collective bargaining agreement within the ten years immediately preceding the effective date of a permanent Disability retirement pension from the Pension Plan.

Additionally, a surviving spouse of a participant who met the eligibility requirements described in paragraph 1 above and who died on or after January 1, 2007 is an eligible participant and entitled to receive benefits if the surviving spouse was married to the participant at the time the participant was awarded a pension by the Pension Plan, and for as long as the surviving spouse continues to receive benefits from the Pension Plan or the Health Plan.

ELIGIBLE DEPENDENTS

Dependents of participants are eligible for coverage if they meet the rules below and if proof of dependent status is submitted to the Administrative Office. Proof of dependent status must be by documentation verifying the relationship of the dependent to the participant and may include such items as marriage certificates, birth certificates, adoption papers and Court Orders. Contact the Administrative Office for details on what documentation must be submitted to establish eligibility for your dependents.

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 through the last day of the month in which the child turns age 19 if the child is dependent on the participant for more than half of the child's support;
- unmarried children from age 19 through the last day of the month in which the child turns age 23, if the child is enrolled as a full-time student (at least 12 units per semester or quarter) in an accredited institution of learning and dependent upon the participant for more than half of the child's support. An unmarried child 19 through 22 years of age who was in school the last month of a semester before summer break and who is enrolled for the following semester will be covered during the summer break. In order for a student 19 through 22 years of age to maintain coverage, the participant must submit to the Administrative Office a student certification form completed by the school registrar twice per year: by March 15 and by September 15 (the form may be obtained from the Administrative Office or at www.sheetmetalsam.org).

If a dependent child eligible under this provision takes a medically necessary leave of absence from school (or changes to part-time student status as the result of a medical

necessity), the child's eligibility may continue for up to 12 months while on such medical leave or part-time status. In order for a student 19 through 22 years of age to maintain coverage while on medical leave (or part time status), the participant must submit to the Administrative Office a written certification from a physician that the child is suffering from a serious illness or injury and that a leave of absence from school (or reduced hours) is medically necessary. The certification must be submitted to the Administrative Office within 30 days following the date the leave of absence (or part-time student status) begins. This maximum one-year extension of coverage begins on the first day of the medically necessary leave of absence or part-time status and ends on the date that is the **earlier** of (1) one year later, or (2) the date on which coverage would otherwise terminate under the terms of the Plan;

unmarried dependent children 19 years of age or older (or 23 if a full-time student) if the child is **solely** dependent upon the participant for support and is totally prevented from earning a living because of a mental or physical disability. The disabled child must have been disabled while covered under the Plan before reaching the limiting age of 19 (or 23 if a full-time student). Alternatively, within the five year period preceding the time the participant began accruing an hour bank leading to the participant's coverage under the Plan, the disabled child must have been disabled while covered under a related multi-employer health plan covering sheet metal workers employed under a collective bargaining agreement with a Local Union affiliated with the Sheet Metal Workers' International Association before reaching the limiting age of 19 (or 23 if a full-time student). The disability must be certified by a physician and such certification must be submitted to the Administrative Office annually.

The term "unmarried children" includes the participant's natural children, legally-adopted children, children "placed for adoption" if under 18 years old, stepchildren, and any other child for whom, by a Qualified Medical Child Support Order (QMCSO), or court order of legal guardianship, the participant is legally responsible for the child's health care expenses. A child is "placed for adoption" with you on the date you first became legally obligated to provide full or partial support for the child whom you plan to adopt. If the participant is the legal guardian of a child who is not a "relative," as described in Internal Revenue Code, Section 152(d)(2)(A) through (G), the child must, for the entire year, have the same principal place of abode as the participant and be a member of the participant's household.

ADDING NEW DEPENDENTS

New eligible dependents must be enrolled within 31 days from the date dependency status is met. Otherwise, the dependent's coverage effective date may be delayed until the first day of the month following the date the Administrative Office receives the required form and required documentation. Contact the Administrative Office for an enrollment form and details on the documentation that must be submitted with the form.

TERMINATION OF ELIGIBILITY

Eligibility will terminate and no benefits will be payable as of the date the participant becomes ineligible for benefits from the Pension Plan or the Health Plan, the date the participant is no longer a member of Local 88, or the date of the payment following the death of the participant or the death of the participant's eligible surviving spouse's (as described on page 4 of this booklet).

WHEN WILL MY BENEFITS BEGIN?

You will be eligible for benefits on February 1 or August 1 following the day you have been receiving pension benefits from the Pension Plan for at least six (6) months.

Example 1: If you began receiving pension benefits from the Pension Plan on December 1, 2008, you became eligible to receive benefits from the Retiree Health Reimbursement Plan for the period January through June 2009. If you timely applied for benefits, you would have received your first benefit payment in August 2009.

Example 2: If you began receiving pension benefits from the Pension Plan on June 1, 2009, you became eligible to receive benefits from the Retiree Health Reimbursement Plan for the period July through December 2009. If you timely applied for benefits, you would have received your first benefit payment in February 2010.

Please note: You will not be reimbursed for expenses incurred before you begin receiving benefits from the Pension Plan. If you receive retroactive pension benefits, you will be eligible for current benefits only (January through June for the August payout, or July through December for the February payout).

In addition, under no circumstances will 'out-of-pocket expenses' be reimbursed until your active hour bank in the Health Plan has been exhausted.

WHEN ARE BENEFITS PAID?

The Plan's goal is to pay benefits in February and August each year. After you have established your eligibility, you will receive reimbursement payment for your eligible expenses incurred in the months of January through June in August of the current year, and for your eligible expenses incurred in the months of July through December in February of the following year.

HOW TO RECEIVE YOUR BENEFITS

Each January and July, you will be sent an "Application for Benefits" along with a declaration form called "Conditions of Entitlement." You must complete, sign and return both documents to the Administrative Office in order to be eligible for the next payment of benefits.

WHAT BENEFITS WILL YOU RECEIVE?

The Trustees will determine the total contributions made into the Trust and, after setting aside sufficient reserves for all anticipated expenses, divide the total amount to be allocated by the number of eligible participants, in order to determine the maximum benefit amount payable per eligible participant. Each eligible participant will receive qualifying benefits, up to the maximum amount payable as determined by the Board of Trustees, in installments during the year (usually one payment each six months).

If an eligible participant dies, his spouse or children will receive one additional installment payment equal to what the participant would have received had the participant lived.

LIMITATIONS AND EXCLUSIONS

- Expenses incurred during any period in which the participant had “Active” Plan A or B coverage under the Health Plan are not reimbursable. Please note, if you are a recent retiree running out your Active Hour Bank under the Health Plan, your eligibility for benefits will begin the first month after your “active” coverage under the Health Plan has terminated. If you are uncertain when your “active” coverage terminated or will terminate, please contact the Health Plan’s Eligibility Department at the Administrative Office.
- Dental, vision and hearing aid expenses which have been paid in full by any other benefit plan are **not** reimbursable.
- Loan payments made for dental, hearing or vision expenses are **not** reimbursable.
- Dental services that are considered cosmetic in nature are **not** reimbursable.
- Premiums and other expenses you have paid for employer-sponsored health, dental or vision insurance or coverage are **not** reimbursable.
- Co-payments or out-of-pocket expenses for medical services and prescription drugs are **not** reimbursable.

Acceptable Proof of Payment for Medical, Dental or Vision Premiums:

- Copies of cancelled checks for premiums paid for medical coverage. The name of the provider must be on each check as well as the month for the premium payment was made.
- Copies of monthly bank statements showing automatic deductions for medical, dental, vision or eligible dependent coverage. Dollar amounts should either be circled or highlighted. To protect your privacy, we suggest that you black-out all other charges and deposits.

- Copies of monthly premium statements for health coverage from individually purchased insurance (not provided by an employer). The plan member's or spouse's name, the name of the provider, the premium amount paid, and the month of coverage should be included.

Acceptable Claims for Dental, Vision and Hearing Aid Out-of-Pocket Expenses

- Itemized statements are required and should include the name of the patient, the date the service was rendered, a description of the service, and the dollar amount the member or dependent is responsible to pay.
- Receipts from the service provider showing the dollar amount the participant paid for the services provided.

BENEFITS ARE NOT GUARANTEED

Benefits are payable only if the Plan is continued by the Board of Trustees or there are sufficient assets to pay benefits. No retiree, employee, beneficiary or family member has a right to any benefit unless: they are eligible under the Rules and Regulations of the Plan (as determined by the Trustees in their sole discretion); there are sufficient assets in the Trust to continue to pay benefits; and the Trustees have determined in their sole discretion to maintain the Plan. The Trustees reserve the right to amend or terminate any rules relating to benefit payments or eligibility in their sole discretion.

CLAIMS AND APPEALS PROCEDURES

No participant or any other person shall have any right or claim to Plan benefits except as specified in the Plan rules. If a participant has a dispute with the Plan or the Board of Trustees as to eligibility or the amount or duration of benefits, the dispute shall be resolved by the Board of Trustees, which shall have the right to construe this Agreement and the Plan and make all necessary factual determinations. The decision of the Board of Trustees shall be final and binding on all parties.

Any participant whose application for benefits is wholly or partially denied shall be notified in writing by the Administrative Office of the decision of the Trust. The notice shall advise the applicant of the reason for the denial, together with an explanation of the applicant's right to appeal the decision.

Thereafter, the applicant may file a written appeal with the Board of Trustees not more than 180 days after the applicant received written notice of the denial of his or her application. Failure to file an appeal within 180 days will constitute a waiver of the applicant's right to appeal, and the decision of the Plan or Trustees will be final and binding.

The appeal must be in writing and must state in clear and concise terms the reason or reasons why the applicant feels that the decision of the Plan or Trustees was in error. All arguments, issues, and comments in support of the appeal must be set forth in the written appeal. To enable

the appellant to perfect his or her appeal, the appellant may examine and receive copies, free of charge, of any relevant documents, records or other information in possession of the Plan.

Upon receipt of a timely filed appeal and the written request of the applicant, the Board of Trustees or a duly constituted committee of Trustees shall grant a hearing to be held within a reasonable time at which the applicant may personally appear in support of his or her appeal.

The Board of Trustees or committee shall render its decision not later than 60 days after the later of the receipt of the written appeal or the hearing. If special circumstances require additional time, the Board or committee shall notify the applicant within 60 days and render its decision as soon as possible but not later than 120 days after receipt of the appeal or hearing.

You will be advised in writing of the decision of the Trustees. The letter 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.

The decision of the Board or committee shall be final and binding upon the applicant and all persons claiming benefits under the applicant.

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. The Plan's appeals procedures must be exhausted before the applicant can avail himself or herself of any administrative, judicial or other forum or procedure.

Information Required by the Employee Retirement Income Security Act of 1974 (ERISA)

1. Name of the Plan. The Plan is the Sheet Metal Workers Local 88 Retiree Health Reimbursement Plan.
2. Type of Plan. The Plan is an employee welfare benefit plan pursuant to ERISA. The Plan provides supplemental benefits in the form of qualifying payment or reimbursement of health premiums and out-of-pocket dental, vision and hearing aid expenses to eligible retired members of Local 88 and their eligible dependents.
3. Plan Sponsor and Administrator. The Board of Trustees is both the plan sponsor and administrator. This means, among other things, that the Board of Trustees is responsible for seeing that information regarding the Plan is reported to government agencies and disclosed to Plan participants and beneficiaries in accordance with the requirements of ERISA. The Plan is administered and maintained by the Board of Trustees at the following address:

Sheet Metal Workers Local 88
Retiree Health Reimbursement Plan
P.O. Box 10067
Manhattan Beach, CA 90266
(800) 947-4338

4. Board of Trustees. The Board of Trustees is responsible for the operation of the Plan. The Board consists of an equal number of employer and employee representatives, selected by participating employers and Sheet Metal Workers Local 88 in accordance with the Trust Agreement governing the Plan. If you wish to contact the Board of Trustees, you may use the address of Sheet Metal Workers Local 88 Retiree Health Reimbursement Plan, P.O. Box 10067, Manhattan Beach, CA 90266. The current members of the Board of Trustees are identified at page 1 of this booklet.
5. Identification Number. The employer identification number assigned to the Plan by the Internal Revenue Service is 52-2445383.
6. Agent for Service of Process. The name and address of the agent designated for service of process is:

Richard Wondra, Administrative Director
Sheet Metal Benefit Plans Administrative Corp.
111 North Sepulveda Blvd., Suite 100
Manhattan Beach, CA 90266-6891
Phone: (800) 947-4338; fax: (310) 798-0766

Legal process may also be served on any Trustee.

7. Collective Bargaining Agreements. Contributions to the Plan are made on behalf of each covered employee in accordance with collective bargaining agreements between Sheet Metal Workers Local 88 and employer associations and individual employers in the sheet

metal industry. Copies of collective bargaining agreements may be obtained by participants and beneficiaries upon written request to the Administrative Office.

8. Trust Fund. All assets are held in trust by the Board of Trustees and are invested in various bank savings accounts and short-term bank investments.
9. Identity of the Provider of Benefits. All benefits are provided directly by the Plan. The complete terms of the Plan are set forth in the Plan's Agreement and Declaration of Trust and its Rules and Regulations.
10. Plan Year. The records of the Plan are kept separately for each plan year. Each Plan year begins January 1 and ends December 31.
11. Sources of Contributions to the Plan. Contributions are made by participating employers pursuant to collective bargaining agreements with Sheet Metal Workers Local 88. A complete list of participating employers may be obtained by participants and beneficiaries upon written request to the Administrative Office,
12. Eligibility and Benefits. The Plan's requirements regarding eligibility for participation and eligibility for benefits, and a description of Plan benefits, are outlined in this booklet and are described more fully in the Rules and Regulations.
13. Statement of ERISA Rights. This Statement of ERISA Rights is required by federal law and regulations.

As a participant in the Sheet Metal Workers Local 88 Retiree Health Reimbursement Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all Plan participants shall be entitled to:

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 Employee Benefits Security Administration.

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

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

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 plan benefit or exercising your rights under ERISA.

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

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

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

For eligibility, benefit, and any other general information or questions, call or write:

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