SHEET METAL WORKERS LOCAL 104 HEALTH CARE PLAN
(As revised January 2021)

Amendment 19

Pursuant to the authority set forth in Article VII of the Agreement and Declaration of Trust, the Trustees hereby amend the Sheet Metal Workers Local 104 Health Care Plan as follows:

1. Effective April 1, 2024, the pharmacy benefit for Medicare-eligible Retirees and Dependents on the indemnity plan is changed to the Sheet Metal Workers Local 104 Health Care Plan Medicare Prescription Drug Plan (PDP), administered by Optum Rx. All references throughout the Summary Plan Description are revised to Sheet Metal Workers Local 104 Health Care Plan Medicare Prescription Drug Plan (PDP), administered by Optum Rx as appropriate.

2. The "Medicare-Eligible Retirees and Dependents" subsection of the "Prescription Drug Benefit" section under the "Indemnity Health Plan Summary of Benefits" heading is revised in its entirety to read as follows:

MEDICARE-ELIGIBLE RETIREES AND DEPENDENTS

Prescription drugs for Medicare-eligible Retirees and Dependents are provided under the Sheet Metal Workers Local 104 Health Care Plan Medicare Prescription Drug Plan (PDP), administered by Optum Rx. See page ___ for a more detailed description of your prescription drug benefits.

ANNUAL DEDUCTIBLE: $0

OUT-OF-POCKET MAXIMUM: $2,500 per individual. Your annual Out-of-Pocket Maximum includes medical and prescription drug expenses that count towards the Out-of-Pocket Maximum. Tier 3 copayments and coinsurance do not count towards your Out-of-Pocket Maximum. For medical expenses that do not count towards your Out-of-Pocket, see "OUT-OF-POCKET MAXIMUM" under the "Medical Benefits" section of this Summary Plan Description.

COPAYMENTS AND COINSURANCE:

Covered Prescription Drugs	**Retail Pharmacy** (up to a 30-day supply)	**Retail Pharmacy** (up to a 90-day supply)	**Home Delivery Pharmacy** (up to a 90-day supply)
Tier 1 Generic Drugs	$15	$30	$30
Tier 2 Preferred Brand Drugs	25% $15 minimum/ $50 maximum	50% $30 minimum/ $100 maximum	50% $30 minimum/ $100 maximum
Tier 3	25%	50%	50%

Non-Preferred Brand Drugs	$15 minimum/ No maximum	$30 minimum/ No maximum	$30 minimum/ No maximum
Tier 4 Insulin and Diabetes Maintenance Medications	$0	$0	$0

3. The "Indemnity Plan Participants Medicare-Eligible Retirees and Dependents" subsection under the "Prescription Drug Benefit" section is revised in its entirety to read as follows:

INDEMNITY PLAN PARTICIPANTS
MEDICARE-ELIGIBLE RETIREES AND DEPENDENTS

Medicare Retirees and Dependents: If you are a Medicare-eligible retiree, you and your other Medicare-eligible family members do not need to enroll in Medicare Part D for prescription drug coverage if you enroll in the Sheet Metal Workers Local 104 Health Care Plan Medicare Prescription Drug Plan, administered by Optum Rx. You must notify the Plan when you become eligible for Medicare so that you can be enrolled in the Sheet Metal Workers Local 104 Health Care Plan Medicare Prescription Drug Program. You must enroll in Medicare Parts A and B. The prescription drug benefits you currently receive under the Sheet Metal Workers Local 104 Health Care Plan are as good as or better than the standard Medicare Part D prescription drug coverage. Enrolling in Part D prescription drug coverage will increase your overall cost without giving you better benefits than the Plan provides and might jeopardize your benefits under the Plan. As long as you have prescription drug coverage under the Plan, you are considered to have "creditable coverage"; therefore, if at some later date you choose to enroll in Medicare Part D, you will not be charged a late penalty for delayed enrollment.

Prescription Drug Benefits: Sheet Metal Workers Local 104 Health Care Plan Medicare Prescription Drug Plan

Prescription drugs for Medicare-eligible Retirees and Dependents are provided under the Sheet Metal Workers Local 104 Health Care Plan Medicare Prescription Drug Program that is administered by Optum Rx. You will receive coverage information, including a summary of benefits, and your prescription drug ID cards directly from Optum Rx.

You can get your prescriptions filled by a pharmacy that is in the Optum Rx network, either from your local retail pharmacy or through a prescription mail-order service. You will pay the same cost-sharing amount (copayment and/or coinsurance) at any network pharmacy.

ANNUAL DEDUCTIBLE: $0

OUT-OF-POCKET MAXIMUM: $2,500 per individual. Your annual Out-of-Pocket Maximum includes medical and prescription drug expenses that count towards the Out-of-Pocket Maximum. Tier 3 copayments and coinsurance do not count towards your Out-of-Pocket Maximum. For

medical expenses that do not count towards your Out-of-Pocket, see "OUT-OF-POCKET MAXIMUM" under the "Medical Benefits" section of this Summary Plan Description.

COPAYMENTS AND COINSURANCE:

Covered Prescription Drugs	**Retail Pharmacy** (up to a 30-day supply)	**Retail Pharmacy** (up to a 90-day supply)	**Home Delivery Pharmacy** (up to a 90-day supply)
Tier 1 Generic Drugs	$15	$30	$30
Tier 2 Preferred Brand Drugs	25% $15 minimum/ $50 maximum	50% $30 minimum/ $100 maximum	50% $30 minimum/ $100 maximum
Tier 3 Non-Preferred Brand Drugs	25% $15 minimum/ No maximum	50% $30 minimum/ No maximum	50% $30 minimum/ No maximum
Tier 4 Insulin and Diabetes Maintenance Medications	$0	$0	$0

Medicare Part B and Part D Excluded Drugs: The Plan offers supplemental coverage on some prescription drugs not normally covered under Medicare Part D and/or Part B.

Coverage Limitations:

- **Prior Authorization:** Some drugs require your provider to get prior authorization (approval) from Optum Rx before the drug will be covered.
- **Step Therapy:** You may be required to try one drug to treat your condition before the Plan will cover another drug for that condition.
- **Quantity Limitations:** There are quantity limits on certain drugs, which means that you can only get a certain amount of a drug within a specified timeframe.

Medication Therapy Management (MTM) Program: This is a free service offered by Optum Rx. The program helps to make sure you are using drugs that work best to treat your medical condition. It can also help Optum Rx identify possible medication errors. If you meet the criteria, Optum Rx will automatically enroll you in the program and send you information. If you do not wish to participate, please let Optum Rx know and you will be removed from the program.

Out-of-Network Pharmacy: If you have prescriptions filled by an out-of-network pharmacy, you must pay the full amount yourself and file a claim with Optum Rx for reimbursement. If the claim is not approved, there will be no reimbursement. If the claim is approved, you will be responsible for your share of the cost (copayment and/or coinsurance described above), plus the

difference between the lower network cost and the amount the pharmacy charged. This difference will not count towards your annual Out-of-Pocket Maximum.

Drug Coverage Determinations/Exception Requests: You have the right to request a coverage determination, which is a decision made by the Plan about a drug that you believe should be covered. You may also ask for an exception if you believe you need a drug that is not on the list of covered drugs or that you believe should be covered at a lower out-of-pocket cost. To make a request, your prescriber should contact Optum Rx

Address:	Optum Rx, Prior Authorization Department P.O. Box 2975 Mission, KS 66201
Phone:	1-866-235-3171, TTY 711 24 hours a day, 7 days a week
Fax:	1-844-403-1028

Once a request is submitted, you will receive a decision from Optum Rx within 72 hours for a standard request, or 24 hours if the request has been expedited. Your request will be expedited if Optum Rx determines, or your prescriber informs Optum Rx, that your life, health, or ability to regain maximum function may be seriously jeopardized by waiting for a standard request.

Appeals: If your coverage for a prescription drug is denied, you have the right to appeal that decision by asking for a review from Optum Rx. Your appeal request must be submitted within 60 calendar days from the date of the written decision on your first coverage determination or exception request.

Address:	Optum Rx, Prior Authorization Department, c/o Appeals Coordinator P.O. Box 2975 Mission, KS 66201
Phone:	1-866-235-3171, TTY 711 24 hours a day, 7 days a week
Fax:	1-844-403-1028

You may also submit an appeal to the Board of Trustees of the Plan. The Plan's Claims and Appeals Procedures begin on page ___ of this Summary Plan Description.

Optum Rx Member Services:

Phone (toll-free):	1-855-235-1405
TTY users:	711
Hours of Operation:	Monday – Friday, 8 a.m. – 8 p.m. PST, except holidays
Website:	optumrx.com

Income Related Monthly Adjustment Amount (IRMAA): This is an additional premium amount that you may be billed for by the Social Security Administration if your modified adjusted gross income as reported on your IRS tax return for 2 years ago is above a certain amount. If your income is $103,000 or more for an individual in 2022 (or married individuals

filing separately) or $206,000 or more for married couples in 2022, you must pay IRMAA in 2024 directly to the government for your Medicare Part D coverage. The income limits are adjusted annually. To maintain your coverage, if you are billed for IRMAA, you must pay it.

4. Effective April 1, 2024, Number 6 under "Eligibility Rules for Retiree Plan Benefits" in the "Retiree Health Plan" section is revised to read as follows:

6. Your first payment for Plan coverage will be due during the first month after which your active coverage ends after your Hour Bank runs out. After that time, regular monthly payments must be received by the Trust Fund Office no later than the 20th day of the month preceding the month of coverage. If you apply for retiree coverage after 12-months of self-pay due to unemployment or disability, your first payment for retiree coverage will still be due the date after your Hour Bank runs out**, and there will be a retroactive adjustment made to the premium if there is any difference between the retiree rate and the self-pay rate, including any payments made on your behalf from either the Supplemental Unemployment or Supplemental Health Care Plans to the Sheet Metal Workers Local 104 Health Care Plan for any period such payments were made after the effective date of your retirement.**

   If you do not pay the required monthly payment by the 20th day of the month preceding the month of coverage, your coverage will be terminated effective the 1st of the month for which payment was not received. However, Medicare-eligible retirees and dependents will be provided with a grace period of two (2) calendar months and notice that is compliant with the requirements of the Centers for Medicare & Medicaid Services (CMS). If the required monthly payments are not paid by the end of the grace period for all amounts owed (including grace period months, if then due), then the retiree and/or dependent(s) coverage will be terminated the first of the month following the end of the grace period.

5. Effective March 12, 2024, the "Appeals Procedures" subsection of the "Claims and Appeals Procedures" is revised to read as follows:

APPEALS PROCEDURES

If you do not receive benefits from the Plan that you feel you are entitled to, you should contact the Trust Fund Office to discuss your claim.

If your claim is wholly or partially denied, you will receive a written notice of denial that will contain the following information:

1. The specific reason for the denial with specific reference to pertinent Plan provisions on which the denial is based;
2. A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material is necessary;
3. Appropriate information as to the steps to be taken if you wish to submit the claim for review;

4. The specific rule, guideline, protocol, or other similar criterion, if any, relied upon in making the determination;
5. An explanation of the scientific or clinical judgment for the determination if the adverse benefit determination was based on medical necessity or other similar exclusion or limitation.

Emergency Care Claims

The determination as to whether a claim involves Emergency Care is determined by the attending provider and the Plan defers to such determination. In the case of an Emergency Care claim, the Administrative Office will notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the seriousness of your medical condition, but not later than 24 hours after receipt of the claim by the Plan, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Administrative Office will notify you within 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. You will be given a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Administrative Office will notify you of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified information; or (2) the end of the period given to you to provide the specified additional information.

Pre-Service Claims

The benefit determination, whether adverse or not, will be given within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the claim is filed, and unless special circumstances beyond the control of the Plan require an extension of time for processing the claim. If such extension is required, you will be sent written notice before the expiration of the initial 15 day period, stating the special circumstances requiring the extension and the date by which a decision on the claim can be expected. If such extension is necessary due to a failure by you to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be given at least 45 days from the receipt of the notice within which to provide the specified information.

Post-Service Claims

The notice of denial will be given within 30 days after the claim is filed, unless special circumstances beyond the control of the Plan require an extension of time for processing the claim. If such extension is required, you will be sent written notice before the expiration of the initial 30 day period, stating the special circumstances requiring the extension and the date by which a decision on the claim can be expected. If such extension is necessary due to a failure by you to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be given at least 45 days from the receipt of the notice within which to provide the specified information.

Concurrent Care Decision

If you are receiving an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of such treatment will be deemed an adverse benefit determination. Notice of such determination will be sent at a time sufficiently

in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

Any request by you to extend the course of treatment beyond the period of time or number of treatments involving an Emergency Care claim will be decided as soon as possible, taking into account the seriousness of your medical condition, and the Administrative Office will notify you of the benefit determination, whether adverse or not, within 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Benefit Determination on Review

If your claim is denied, you have a right to appeal by submitting a written application to the Board of Trustees within 180 days. If the benefits involved are provided by an insurance company, insurance service, Health Maintenance Organization (HMO), Pharmacy Benefit Manager (PBM) or other similar organization, the Trustees may permit that organization to conduct the review and make the decision. You or your representative may review the Plan documents and submit written comments to the Trust Fund Office, but shall have no right to appear personally before the reviewing group unless that group concludes that such an appearance would be of value in enabling it to perform its obligations hereunder. Appeals will be reviewed and decided on by the Board of Trustees or the Appeals Committee. However, the Board of Trustees or Appeals Committee may delegate this power to an authorized designee or other committee of Trustees.

In the case of a claim involving Emergency Care, a request for an expedited appeal for an adverse benefit determination may be submitted orally or in writing by you or your duly authorized representative, and all necessary information, including the Plan's benefit determination will be transmitted to you by telephone, facsimile, or other available similarly expeditious method.

You or your duly authorized representative will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. Relevant information includes identification of any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit decision. You will also be provided any statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination. The Trustees will not afford any deference to the initial benefit determination. If the adverse benefit determination is based in whole or in part on a medical judgment, the Board of Trustees will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. Such consultant will be different from any individual consulted in connection with the initial determination or the subordinate of any such person.

Emergency Care Claims

You will be notified of the Plan's benefit determination on review as soon as possible, taking into account the seriousness of your medical condition, but not later than 72 hours after receipt of your request.

Pre-Service Claims

You will be notified of the Plan's benefit determination on review within a reasonable time, but not later than 30 days after receipt by the Plan of your request for review of an adverse benefit determination.

Post-Service Claims

Upon receipt of a petition for review, the Trustees or a committee appointed by the Trustees and authorized to act on such petitions, will proceed to review the administrative file, including the petition for review and its contents. All comments, documents, records and other information submitted by you relating to the claim will be taken into account without regard to whether such information was submitted or considered in the initial benefit determination. A decision by the Trustees will be made at the next succeeding regular Trustees' meeting following the request for review, except that a request for review received within thirty (30) days preceding the date of such meeting. In such case, a benefit determination may be made no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination will be made no later than the third meeting following the receipt of the petition for review. Notification of the extension will be sent to you prior to the commencement of the extension describing the special circumstances and the date by which the benefit determination will be made. You will be notified of the decision of the Trustees in writing within five (5) days after the benefit determination is made.

Any notice of adverse benefit determination will be in writing and include the following:

1. The specific reason or reasons for the adverse determination;

2. Reference to the specific Plan provisions on which the benefit determination is based;

3. A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relevant to Claimant's claim;

4. A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures;

5. A statement of your right to bring an action under ERISA Section 502(a);

6. The specific rule, guideline, protocol, or other similar criterion, if any, relied upon in making the determination; and

7. An explanation of the scientific or clinical judgment for the determination if the denial was based on medical necessity or other similar exclusion or limit.

In the event that you desire additional time to present evidence in support of your petition for review, you may request such additional time in writing. The Trustees will grant your written request for additional time necessary to perfect a petition for review, provided the written request is received before the Trustees issue their decision. Requests for additional time and requests to submit additional information received after the Trustees' decision has been rendered will be denied, unless the Trustees, in their sole discretion, determine that the information is material to the petition and could not have been provided earlier.

If the benefits involved are provided by an insurance company, insurance service, HMO, or other similar organization, that organization may be entitled to conduct the review and make the decision. Disputes concerning benefits provided by an HMO generally must be resolved using the appeal procedure established by that organization. See the applicable HMO brochure for details of the organization's claims and appeals procedures. As part of the review procedure, you or your authorized representative may review pertinent documents and submit issues and comments in writing.

The Trustees have full discretionary authority to interpret all plan provision and to make all factual determinations concerning any claim or right asserted under or against the Plan or Trust Fund. The Trustees and/or the Appeals Committee have absolute discretion to grant an appeal if, based on the specific facts and circumstances, it is in the best financial interest of the Plan.

The decision of the Trustees shall be final. No lawsuit may be filed without first exhausting the above appeals procedure. In any such lawsuit, the determination made by the Trustees are subject to judicial review for only abuse of discretion. No legal action may be commenced or maintained against the Plan more than two (2) years after a claim has been denied.

This Amendment 19 was adopted by the Board of Trustees on June 21, 2024. The Chairman and Co-Chairman were authorized by the Board of Trustees to execute this Amendment on their behalf. This Amendment 19 may be executed in counterparts, each of which shall be deemed to be an original, but all of which together shall constitute one and the same Amendment 19.

Chairman

Date: 6/25/2024 | 9:41 AM EDT

Sean O'Donoghue

Co-Chairman

Date: 6/30/2024 | 2:26 PM PDT