SUMMARY FUND DESCRIPTION

TEAMSTERS LOCAL NO. 1150 PRECRIPTION DRUG BENEFIT FUND

January 2020
Edition

TEAMSTERS 1150 PRESCRIPTION DRUG BENEFIT FUND

ZENITH AMERICAN SOLUTIONS
10 Technology Drive
Wallingford, CT 06492

January 2020

Dear Participant:

This Summary Plan Description ("SPD") describes the **TEAMSTERS 1150 PRESCRIPTION DRUG BENEFIT FUND** in effect as of January 1, 2020, and the benefits available under the Plan. The Teamsters 1150 Prescription Drug Fund provides prescription drug benefits in conjunction with your Lockheed Martin Group Benefits Plan, for Employees of Sikorsky Aircraft Corporation, a Lockheed Martin Company (herein referred to as "Sikorsky Group Benefits Plan"). This Teamsters 1150 Prescription Drug SPD is distributed with and it is intended to be read in conjunction with the Sikorsky Group Benefits Plan Summary Plan Description. The contents of this booklet together with the Sikorsky Group Benefits Plan SPD describe the benefits under Teamsters 1150 Prescription Drug Fund and the rules and regulations adopted by the Teamsters 1150 Prescription Drug Fund Trustees for the administration of the Teamsters 1150 Prescription Drug Fund. The rules for eligibility for benefits in the Teamsters 1150 Prescription Drug Fund are described in the Sikorsky Group Benefits Plan SPD, except as amended, expanded or changed in any way by this Teamsters 1150 Prescription Drug SPD.

Benefits change regularly and you are notified at least annually of these changes. Also enclosed are all notices of such changes to Teamsters 1150 Prescription Drug Fund since the publication of this SPD (if you are receiving this booklet on or about the date above, there have been no such changes, yet).

The Teamsters 1150 Prescription Drug Fund is administered by a Board of Trustees, who are appointed in equal number by the Teamsters Local 1150 and Lockheed Martin Corporation. The Trustees have broad authority and the maximum discretion permitted under applicable law when construing the terms of the Plan, including but not limited to the discontinuance of benefits, eligibility status, the level of benefits, and the interpretation and application of the terms of the Plan to a particular claim. Trustee discretionary decisions shall be accorded a deferential rather than *de novo* standard of review by the courts and such decisions may only be overturned if they are determined to be an abuse of that discretion or otherwise arbitrary and capricious.

No Local Union, Local Union officer, business agent, Local Union member, Employer, agent of an Employer, Fund Office personnel or consultant is authorized to speak for or on behalf of, or to commit the Trustees of the Teamsters 1150 Prescription Drug Fund on any matter relating to the Fund without express written authority from the Trustees.

The Trustees reserve the right to amend, modify or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant, or when sufficient assets are not available to pay for benefits. This document is not an employment contract or a guarantee of the terms of employment.

Be sure to read this booklet carefully so that you are familiar with the benefits. It should be kept with your Sikorsky Group Benefits Plan SPD. If you do not understand English and have a question about the benefits or the rules of the Fund, contact the Fund Office for assistance.

Si usted no entiende ingles o si tiene una pregunta acerca de los beneficios o las reglas del Fund, llame la Oficina del Fund para asistencia.

Sincerely,

BOARD OF TRUSTEES

IMPORTANT CONTACT INFORMATION

In addition to the contact information provided in the Sikorsky Group Benefits Plan SPD, you can get more information about the benefits available from the Teamsters 1150 Prescription Drug Benefit Fund at:

The Teamsters Local No. 1150 Web Site at www.teamsters1150.org

You can also use the contact information listed below for additional information and to ask questions about the benefits described in this booklet.

Allegiant Rx (pharmacy benefit manager)	**1-866-888-0103 (Help Line)**
OptumRx Home Delivery Services	**1-844-805-9802**
Zenith American Solutions (administrator)	**1-800-446-8646**

P.O. Box 5817
10 Technology Drive
Wallingford, CT 06492

To mail a prescription to the OptumRx Home Delivery Services:

OptumRx
P.O. Box 2975
Mission, KS 66201

ELIGIBILITY

The general eligibility rules for the Sikorsky Group Benefits Plan govern the general eligibility for Teamsters 1150 Prescription Drug Fund benefits, including termination of eligibility and coverage after retirement. Please refer to “About Your Participation” in the Sikorsky Group Benefits Plan. Additional eligibility provisions may apply for certain benefits. They are described in other sections of this SPD and/or the relevant Sikorsky Group Benefits Plan SPD.

In general, if you have questions about your eligibility for the prescription drug benefits described in this booklet, you should access the Lockheed Martin Employee Service Center website (LMPeople>Benefits>LM Employee Service Center) or *call 866-562-2363* toll free.

PRESCRIPTION DRUG IDENTIFICATION (ID) CARDS

If you enroll for prescription drug benefits through the **Teamsters 1150 Prescription Drug Benefit Fund**, you will receive two ID cards in the mail from OptumRx. Your ID card contains important information, including your prescription drug ID number and instructions on what to do in an emergency. Always remember to carry your prescription drug ID card with you and to present it each time you need to fill a prescription at a retail pharmacy. A “Welcome Kit” will be mailed to you in mid-December, which will include your ID cards.

HEALTH CARE SPENDING ACCOUNT

If you are eligible for a Health Care Spending Account, it can be used to pay the prescription drug co-pays described below. Please refer to the Summary Plan Description for Certain Non-Represented and Represented Employees of Lockheed Martin Corporation regarding the Health Care and Dependent Care Spending Accounts.

In general, if you have questions about your Health Care Spending Account, you should look in the above-referenced Summary Plan Description or contact Benefit Wallet the Health Care Spending Account administrator at **1-855-800-1602**.

PRESCRIPTION DRUG BENEFITS

This SPD describes the prescription drug benefit provided under the Teamsters 1150 Prescription Drug Benefit Fund, which includes retail and mail order benefits administered by AllegiantRx in partnership with OptumRx.

If you have any questions regarding prescription drug benefits, you may call the AllegiantRx help desk at: **1-866-888-0103**, Monday through Friday, 8am to 5pm

- If the Plan's actual cost for a prescription is less than the applicable co-payment, you will only be charged the Plan's actual cost.
- Wal-Mart and Sam's Club pharmacies are excluded from the Fund's retail pharmacy network.

OptumRx Mail-Order Pharmacy

"Build Your Own" Plans

Generic Drugs	$20.00 co-payment
Brand Name Drugs (no generic substitution available)	25% co-payment $55.00 minimum $135.00 maximum
Brand Name Drugs (generic substitution available)	not covered at mail order

"High Deductible" Plans

Until you meet your annual Deductible, you must pay for 100% of the cost of your prescriptions. (The amount of your Deductible depends on the plan design you choose and the plan level you choose.)

- Note: there may be certain "preventive" medications in addition to the "Preventive Care" described below which are covered with a 20% Co-pay even before you meet your annual Deductible.
- Note: Any penalties you incur for failing to follow the plan design will not be applied to your annual Deductible or your annual Out-of-Pocket maximum.

After you meet your Deductible:

All Prescriptions	20% co-payment
Brand Name Drugs (generic substitution available)	not covered at mail-order

OptumRx will dispense up to a 90-day supply of a drug, subject to the prescription written by your physician. Mail-order prescriptions will not be filled at dosages that exceed the manufacturers or U.S. Food & Drug Administration guidelines, unless, after medical review, such dosage is deemed to be medically necessary and appropriate. There may also be legal restrictions in particular states, which limit either the number of refills or the number of days' supply of certain prescriptions, such as opiates, that can be dispensed. If the Plan's actual cost for a prescription is less than the applicable co-payment, you will only be charged the Plan's actual cost.

Mail Order Procedure (The following referenced forms will be mailed to you after enrollment)

1. Complete the OptumRx New Prescription Mail-In Order Form
2. Mail or fax the forms to the OptumRx mail-order pharmacy (envelope included)
3. Have your physician mail, fax, call or e-prescribe your prescription(s) for up to a 90-day supply with up to three (3) refills = One year supply - ***Faxed prescriptions must originate from the doctor's office***
4. You may also mail a mail-order prescription to OptumRx at the address in the front of this SPD. Remember, OptumRx will not accept faxed prescriptions unless faxed by the provider.
5. Your prescription(s) will be sent to you via US Mail or UPS.

Note: Some medication will require a signature and will be sent UPS, signature required. Such medications will not be sent to a P.O. Box. If no one will be home to sign for the delivery, you must supply an alternate address (work, neighbor, etc.) so that a signature may be obtained.

Mandatory Use of OptumRx Mail Order Pharmacy

You must use the Home Delivery Pharmacy Program after the initial fill and two (2) refills of any maintenance medication (determined based on medication NDC number and dosage). Separate prescriptions for the same medication and dosage will be combined in determining the number of fills and refills for a medication. For any medication that you will be taking requiring more than two (2) refills, ask your Physician to write a prescription for a 90-day supply of medication. The number of times that prescription can be refilled will also be noted on the Physician's prescription.

- Specialty medications are dispensed through OptumRx Specialty Pharmacy. Specialty medications are usually injectable medications for specific diseases. Examples of specialty medications: Enbrel, Humira, Copaxone, Avonex, Rebif, etc. Please call AllegiantRx for further information on specialty medications.

Retail Pharmacy Purchases: **For emergency or immediate needs, max of 30 day supply or 100 doses whichever is less**

“Build Your Own” Plans

Generic Drugs	$10.00 co-payment
Brand Name Drugs (no generic substitution available)	25% co-payment $20.00 minimum $50.00 maximum
Brand Name Drugs (generic substitution available)	$10.00 plus difference between cost of drugs

Note: Brand name drugs that have a generic substitute (or alternative, in certain cases) are only available through a retail pharmacy. Your co-payment will be $10.00 plus the difference in cost between the brand name and the generic drug.

“High Deductible” Plans

Until you meet your annual Deductible, you must pay for 100% of the cost of your prescriptions. (The amount of your Deductible depends on the plan design you choose and the plan level you choose.)

- Note: there may be certain “preventive” medications in addition to the “Preventive Care” described below which are covered with a 20% Co-pay even before you meet your annual Deductible.

- Note: Any penalties you incur for failing to follow the plan design will not be applied to your annual Deductible or your annual Out-of-Pocket maximum. If you choose a brand name drug that has a generic version available, the difference in price between the brand name and the generic version will not be applied to your annual Deductible or your annual Out-of-Pocket maximum.

After you meet your Deductible:

All Prescriptions 20% co-payment

Preventative Care: **Covered with no co-pay**

The Fund covers certain preventative medications with no copay. This list is updated annually. Lists of preventative medications or categories of preventative medications covered without co-pay are posted on the web at optumrx.com. If you do not have access to the internet you can call **800-446-8646** for a paper copy.

PLEASE NOTE: Benefits are ***only*** payable for medications dispensed ***with a prescription*** – even for the over-the-counter (OTC) medications, you must have a prescription in order to be covered by the Fund.

1. **SMOKING CESSATION** - A 90-day supply of all OTC and prescription smoking cessation products for participants 18 years old in a rolling 365-day period – except for Chantix (which has a separate limit of 180 days of therapy per rolling 365-day period).

2. **ASPIRIN FOR CARDIOVASCULAR PROTECTION** – OTC aspirin for cardiovascular protection for males from age 45 until their 80th birthday, only, and for females from age 55 until their 80th birthday, only.

3. **FOLIC ACID FOR WOMEN CONSIDERING PREGNANCY** – OTC folic acid for females until their 51st birthday, only.

4. **IRON SUPPLEMENTS TO PREVENT ANEMIA IN INFANTS** – OTC iron supplements for infants until their first birthday, only.

5. **FLUORIDE FOR CHILDREN UNDER AGE 6** – Prescription fluoride products for children until their sixth birthday. After their sixth birthday, prescription fluoride products will be covered with the current co-pay.

6. **VACCINATIONS** –
   a. For flu, hepatitis, pneumonia, zoster, childhood diseases (*mumps, measles, etc.*), meningitis, tetanus and diphtheria at participating in-network retail pharmacies.
   b. For rabies and travel/bioterrorism at participating in-network retail pharmacies with the applicable co-pay.

   Please note that the types of vaccinations offered at different network pharmacies may vary. Vaccines provided in other settings continue to be covered under the Plan with applicable co-pays.

7. **CONTRACEPTIVES**
   a. DIAPHRAGMS –diaphragms for females through their 51st birthdays, only.

OTC spermicides/spermicidal jelly are not covered.

b. HORMONAL CONTRACEPTIVES –
   1. Oral Contraceptives – All generic prescription oral contraceptives and all brand name prescription oral contraceptives for which there is no generic substitute for females until their 51st birthdays. For females after their 51st birthdays, such prescription oral contraceptives will continue to be covered with the applicable co-pay.
   2. Injectable Contraceptives – All prescription injectable contraceptives for females until their 51st birthdays. For females after their 51st birthdays, such prescription injectable contraceptives will continue to be covered with the applicable copay.
   3. Vaginal Ring Contraceptives – All prescription vaginal ring contraceptives for females until their 51st birthdays. For females after their 51st birthdays, vaginal ring contraceptives will continue to be covered with the applicable copay.
   4. Implantable Contraceptives – Are not covered by the Fund.
c. EMERGENCY CONTRACEPTIVES – Prescription and OTC emergency contraceptives for females until their 51st birthday.

Out-of-Pocket Maximums

Build Your Own Plan

The prescription drug benefit offered in combination with the “Build Your Own” (BYO) Medical Plan will include a separate annual out-of-pocket expense cap – meaning, that after you or your family, as the case may be, spend out of your pocket the following amounts for prescription drugs in a year, the remaining prescription drug benefits for the year are covered by the Fund at 100% of covered charges. The annual out-of-pocket cap (for prescription drugs) for a single participant is $2,550 and the annual out-of-pocket cap for a family is $2,950. Separate caps continue to apply to the BYO medical plans.

High Deductible Plan

The prescription drug benefit offered in combination with the “High Deductible” Medical Plan has a blended annual out-of-pocket expense cap – meaning, that after you or your family, as the case may be, spend out of your pocket the amounts outlined in those plans for prescription drugs and/or medical services in a year, the remaining prescription drug benefits for the year are covered by the Fund at 100% of covered charges. The annual out-of-pocket caps are outlined in the relevant Sikorsky Group Benefits Plan SPD.

Utilization Management:

Prior Authorization – Certain medications or classes of medications require prior authorization before they will be covered by the Fund. It is your responsibility to contact AllegiantRx or OptumRx to request prior authorization; however, your provider or pharmacist will often make contact on your behalf.

Drug Quantity Management – Limits the quantity of certain prescriptions to FDA-approved dosage guidelines and other supportive evidence.

Step Therapy – Certain medications will not be dispensed until preferred medications have been tried.

Details, including lists of medications or categories of medications subject to these new programs are posted on the web at optumrx.com. If you do not have access to the internet you can call **800-446-8646** for a paper copy.

The following are not covered as part of your prescription drug benefit:

1. Therapeutic devices or appliances, even if medically necessary
2. Smoking cessation drugs, except under Preventative Care, above
3. Drugs dispensed in a hospital, physician's office, nursing home or other approved facility
4. Biological sera
5. Prescriptions for hyperalimentation
6. Refills beyond the prescribed limit
7. Refills more than one year from the original prescription order date
8. Refills prior to finishing 75% of the projected dosage
9. Drugs used to treat infertility
10. Weight loss medications
11. Vitamins and dietary supplements, except under Preventative Care, above
12. Drugs subject to the "Plan Exclusions"
13. Over The Counter (OTC) drugs or medicines available without a physician's prescription, except under Preventative Care, above
14. Prescriptions payable under a Workers' Compensation law, or other related law or statute
15. Prescriptions for which a third party may be liable
16. Lost or stolen medication
17. Experimental drugs or experimental use of approved drugs

DEFINITIONS

Adverse Benefit Determination means a denial, reduction, termination of or failure to make payment (in whole or in part) for a benefit.

Concurrent Claim means a claim for additional treatment that is being considered concurrently with the provision of treatment and results in a reduction, termination or extension of a benefit. It also means a claim that is reconsidered after an initial approval was made.

Fund means the Teamsters 1150 Prescription Drug Fund in regard to the benefits described herein.

Fund Office means the location of the administrator of the prescription drug benefits; the responsibility for which has been delegated by the Board of Trustees of the Teamsters 1150 Prescription Drug Fund

Post-Service Claim means a claim that is not a Pre-Service, Urgent Care, or Concurrent Claim (for example, a claim submitted for payment after health services and treatment have been obtained).

Pre-Service Claim means a claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before medical care is obtained. Under this Plan, prior approval of services is required for all hospital admissions, gastric bypass surgery, mental health and substance abuse inpatient hospitalization. If you fail to pre-certify these services, benefits will be reduced or in some cases, no benefits will be payable for those services.

Trustee means one of the employer or union representatives on the Board of Trustees of the Teamsters 1150 Prescription Drug Fund.

Urgent Care Claim means a claim for pre-certification of benefits for treatment that, if not received, (1) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (2) 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.

COORDINATION OF BENEFITS

You may have coverage for prescription drugs under two plans: under the Teamsters 1150 Prescription Drug Benefit Plan and another group health plan or Medicare (or coverage under homeowner's insurance or automobile insurance or general or other liability insurance policy may be available to pay prescription drug benefits for you).

> If you ***do*** have coverage for prescription drugs under two plans, when you fill your prescription at a retail pharmacy, you can present both your Teamsters 1150 Prescription Drug Benefit ID card ***and*** your ID card from you other insurance and the Teamsters 1150 Prescription Drug Plan will pay as secondary.

1. Your other coverage, the "Primary Payer", will cover a prescription to the full extent of the allowable expenses under that plan. ("Allowable expense" means the amount payable under the terms of *that* Plan of Benefits for a prescription.) After the Primary Payer pays the allowable expense under that plan, if any, the Teamsters 1150 Prescription Drug Plan, the "Secondary Payer", will pay any balance up to the allowable expense under the Teamsters 1150 Prescription Drug Plan. **Please Note: The allowable expense under the Teamsters 1150 Prescription Drug Plan will be subject to the Fund's deductible and co-pay and any other cost-share rules.

2. The Fund *will NOT* coordinate benefits for mail order prescriptions.

3. The Fund's utilization review and limitation rules such as those regarding "mandatory mail order" and "prior authorization" and "quantity limits" will not apply to prescriptions for which the Fund is the Secondary Payer.

4. The total payment you receive from all sources combined may not exceed 100% of the Fund's "allowable expense." If an employer-sponsored Health Maintenance Organization is determined to be the Primary Payer, the Plan will only pay the required co-payments.

WHEN THIRD PARTIES MAY BE LIABLE

The Fund is a self-insured employee welfare benefit Fund governed by ERISA. ERISA pre-empts any state law purporting to restrict the Fund's rights to reimbursement. The following provisions apply to Fund expenses incurred on behalf of any participant directly or indirectly related to an act or omission of a third party.

The Fund does not cover any expenses directly or indirectly related to an act or omission of a third party, except for injuries sustained as a victim of Domestic Violence. This exclusion applies if the injury, illness or loss resulting from the act or omission of a third party occurred while you are covered by the Fund or before you were eligible for coverage. However, the Trustees may, in their sole discretion, advance coverage for such expenses. The Trustees may also, in their discretion, retain all benefits related to an injury, illness or loss until the final disposition of any claim related to such act or omission.

IF THE FUND INCURS EXPENSES THAT ARE THE RESPONSIBILITY OF A THIRD PARTY, INCLUDING BUT NOT LIMITED TO AN INSURANCE COMPANY, YOU MUST REIMBURSE THE FUND.

The Fund will have the right to be reimbursed from the proceeds of any recoveries, settlements, awards or judgments you or anybody on your behalf obtain from a third party or insurance carrier to the full extent of the total benefits paid to you or on your behalf, even if they are paid in error. The Fund will hold a first priority lien on such recoveries, settlements, awards or judgments. This includes but is not limited to any recovery under the uninsured or underinsured motorist provision of your automobile insurance or pursuant to your homeowner's policy.

The Fund's Reimbursement Rights

- The Fund's lien must be satisfied as a first priority ahead of you, your attorneys, or any other person from the proceeds of such recovery, settlement, award or judgment.

- The Fund must be reimbursed before any such proceeds are disbursed, regardless of whether you receive such proceeds or they are received by a person acting on your behalf. By accepting benefits in such circumstances, you agree that any recoveries, settlements, awards or judgments shall constitute Fund assets to the extent of the benefits paid or to be paid by the Fund. By accepting benefits in such circumstances you agree on behalf of yourself and your attorney or any person acting on your behalf that any person who receives such assets shall hold them in constructive trust for the Fund until the Fund is reimbursed.

- The Fund has the right to be reimbursed to the full extent of its expenses without any reduction for attorneys' fees or any other costs or expenses.

- The Fund has the right to be fully reimbursed whether or not you are fully compensated for your damages or medical expenses.

You are required to notify the Fund of any claim you make for damages or other recovery against a third party or an insurance carrier. You are required to immediately notify the Fund if you receive any recoveries, settlements, awards or judgments from any source. You are required to reimburse the Fund from such recoveries, as stated herein.

As a participant in the Fund, if you accept benefits advanced in such circumstances, you are bound by the obligation to reimburse the Fund and are subject to its right to be reimbursed, as outlined in this section, as are your attorneys, your agents, assigns or heirs and executors. You acknowledge that any legal expenses are your own responsibility, and that it is your obligation to notify your attorney of these provisions and assignment.

YOUR OBLIGATIONS

You and your attorney, if you have retained one, must complete any forms supplied by the Fund and/or by your medical plan, such as an agreement to reimburse the Fund and/or an acknowledgement of the Fund's lien and supply all requested information that the Fund may require. The Fund will not pay claims related to such injury, illness or loss if you do not comply with the Fund's requirements.

However, if the Fund advances you such benefits without your fulfillment of these requirements, the Fund's right to enforce these Fund provisions and the Fund's right to be reimbursed from the proceeds of any recoveries, settlements, awards or judgments, as described above, shall be unaffected.

You are required to notify the Fund of any claim you make for damages or other recovery against a third party or an insurance carrier. You are required to immediately notify the Fund if you receive any recoveries, settlements, awards or judgments from any source. You are required to reimburse the Fund from such recoveries, as stated herein.

As a Participant, whether or not you fulfill these Fund requirements, if you accept benefits advanced in such circumstances, you are bound by the obligation to reimburse the Fund and are subject to the Fund's right to be reimbursed, as outlined in this section, as are your attorneys, your agents, assigns or heirs and executors. You acknowledge that any legal expenses are your own responsibility, and that it is your obligation to notify your attorney of these provisions and assignment.

The Fund's Subrogation Rights

The Fund will have the right to subrogate to any rights you may have against a third party or insurance carrier to the extent of the Fund's expenses. The Board of Trustees may intervene in or subrogate to your interest in any related claim or cause of action against a third party or insurance carrier in order to secure reimbursement of the Fund's expenses.

Enforcement Procedures and Remedies

If you and/or your attorney(s) fail to reimburse the Fund for such expenses, the Fund may bring suit under ERISA to recover its expenses. If the Fund files such legal action, you will be responsible for:

- The costs and expenses necessary to secure the reimbursement, including attorneys' fees, and
- Compound interest at the rate of twelve percent (12%) per annum, compounded monthly.

In addition to any other remedy that may be available under applicable law, the Board of Trustees may exercise the following remedies if you fail to comply with your obligations as stated in this section:

- If you and/or your attorneys fail to cooperate with the Fund, in any way, the Board may assume that you do not intend to honor the Fund's lien and may instruct the Fund to decline to pay any benefits to which you and your dependents would otherwise be eligible until the matter is resolved;
- The Fund may deduct any non-reimbursed expenses from claims otherwise payable to you and/or your dependents until the Fund recovers all of its expenses;
- The Trustees may disqualify you from eligibility for obtaining benefits fraudulently; or
- Any other remedy that the Trustees deem necessary to secure reimbursement.

Any recoveries, settlements, awards or judgments against a third party or insurance carrier will be considered the final resolution of all claims related to the underlying incident, injury or illness regardless of whether you were covered under the Fund at the time of the incident. The Fund will not be responsible for any expenses directly or indirectly related to any loss sustained in the incident you recover in any way from a third party.

Work-Related Injuries or Illnesses

The Fund does not cover any expenses directly or indirectly related to a work-related injury or illness unless the related claim is denied by the Workers' Compensation Commission. Any claims related to a work-related injury or illness must be submitted to Workers' Comp. However, the Board of Trustees may, in their sole discretion, advance coverage if you have been notified in writing that your employer is contesting liability and if you provide a copy of such notice to the Fund Office and you comply with all of your obligations under this Section.

If the Workers' Comp. Commissioner determines that the expenses forwarded by the Fund are the responsibility of your employer, the Fund will seek reimbursement of such expenses from your employer's Workers' Compensation insurance carrier. However, if your employer's Workers' Compensation insurance carrier does not fully reimburse the Fund, the Trustees may use any method available to secure reimbursement, including deducting any non-reimbursed expenses from claims otherwise payable to you and/or your Dependents until the Fund recovers all of its expenses.

If you receive any proceeds from the settlement or final adjudication of your Workers' Comp. claim, the Fund will not provide any benefits related to such claim. Nevertheless, if the Fund makes such payments in error or based on misinformation or lack of information, you must reimburse the Fund for such payments, plus all costs of collection, including interest, attorneys' fees and court costs.

If the Workers' Comp. Commission determines that you are no longer eligible for certain benefits because they are not medically necessary, such benefits will not be covered under the Fund.

Coordination with "Personal Injury Protection"

"Personal Injury Protection" ("PIP") (also known as "Med Pay" coverage) is a provision of automobile insurance that, in the event you are in an accident, covers some of your medical expenses, regardless of who was at fault in the accident.

Florida requires that every driver must carry PIP. PIP is available in Connecticut, but not required. The Fund will only provide coverage after your PIP threshold has been met.

If you live in a state that requires PIP coverage, such as Florida (also Massachusetts and New York, for instance), the Fund will only cover expenses after your PIP minimum coverage has been exhausted, even if you do not carry the required PIP coverage. Therefore, for drivers in these states, the Fund must first obtain either (a) proof that the driver has PIP coverage and that it has been exhausted with copies of covered medical bills or (b) proof of payment of medical expenses related to the accident up to the minimum coverage threshold, before any benefits are paid by the Fund.

The Board of Trustees may establish rules and regulations to govern procedures hereunder.

IMPORTANT INFORMATION ABOUT YOUR CONTINUATION OF COVERAGE RIGHTS UNDER COBRA

Please refer to the Sikorsky Group Benefits Plan SPD for important information about your right to COBRA continuation coverage, which is a temporary extension of health coverage only (i.e., medical, hospitalization, dental, prescription drug and vision coverage). Prescription drug benefits are provided by this Fund. The Sikorsky Group Benefits Plan SPD generally explains COBRA continuation coverage, when it may become available to you and your dependents, and what you need to do to protect the right to receive it. However, this Section will provide you with general information about your COBRA rights.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family when they would otherwise lose their group health coverage. For additional information about your rights and obligations under Sikorsky Group Medical Plan and under federal law, you should use the applicable SPD.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of coverage when coverage would otherwise end because of a life event known as a “qualifying event.” After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You and your dependents would be considered qualified beneficiaries if coverage is lost because of a qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If You Have Questions

Questions concerning your benefits or your COBRA continuation coverage rights should be addressed using the contact information in the Sikorsky Group Benefits Plan SPD. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health funds, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefit Security Administration (EBSA) in your area, or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA’s website.)

HOW TO FILE A CLAIM

REMEMBER, AS A PARTICIPANT, YOU HAVE AGREED TO BE BOUND BY THE FUND'S RULES AND REGULATIONS DESCRIBED IN THIS SPD AND ADMINISTERED BY THE BOARD OF TRUSTEES.

A claim for benefits is a request made in accordance with these claims procedures for the Fund to pay benefits as outlined in this SPD.

General inquiries about the Fund's provisions or eligibility questions that are unrelated to any specific benefit claim—or requests to add or improve the Fund's benefits—will not be treated as claims for benefits. In addition, a request for proof of coverage of a benefit is not a claim for benefits.

OptumRx processes mail order prescriptions and retail prescriptions.

CLAIMS AT A RETAIL PHARMACY

In most cases, your pharmacist(s) will send claims directly to OptumRx. If, for some reason, you have incurred an out-of-pocket expense that is covered under the Fund, please contact the Fund Office.

Claims must be filed within twelve (12) months from the date the charges were incurred or the date you become eligible for the benefit.

In the event that a claim is denied for lack of information, you will be informed of the additional information necessary to complete the claim. You must submit the requested information no later than twelve (12) months after the date that it was requested. No claim will be paid if the Fund receives this information more than twelve (12) months after it is requested.

When a Claim is Considered Received by the Fund

A *Post-Service Claim* is considered received on the first business day when the claim is received by U.S. mail or hand-delivered to Teamsters Rx or the retail pharmacy. Or, on the first business day when the claim is received electronically.

Concurrent, Pre-Service and Urgent Care Claims are generally requests for pre-certification of a prescription that is required by the Fund. A Concurrent, Pre-Service or Urgent Care claim is considered received when a telephone call is made to Allegiant Rx at the telephone number in this SPD, or your provider electronically contacts the Teamsters Rx at its electronic address requesting pre-certification.

ADVERSE BENEFIT DETERMINATIONS

Notice of a Denied Claim

The notice of an Adverse Benefit Determination will include, where applicable:

- the specific reason for the denial;
- the particular provision in this SPD upon which the denial is based;
- a description of any addition information may need to complete the claim and why;
- if the denial was based on an internal Fund guideline or rule, a copy of the rule or guideline or a statement that it is available free of charge;
- if the denial is based on medical evidence, an explanation of the scientific or clinical judgment applied to the terms of the Fund; and
- an explanation of the Fund's appeal procedures, including deadlines.

All claims communications will be addressed to and sent to the individual for whom the prescription is written, if he is 16 years old or older, unless the individual makes a written request to the Fund specifically requesting that any claims communications be sent to a different individual and/or to a different address. Claims communications for individuals under 16 will be sent to their custodial parent.

When the Fund Must Respond to a Claim

<u>For Post-Service Claims</u>

If your claim for benefits is denied in whole or in part, you will be informed in writing as soon as reasonably possible, but not more than 30 days after the receipt of the claim. Allegiant Rx may notify you before the end of this 30-day period in writing of the need for a 15-day extension for reasons beyond their control.

If Allegiant Rx needs more information from you to complete your claim, you will have 45 days from the date such information is requested to provide it, or your claim will be denied without further notice. During the period provided to you to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier).

<u>For Urgent Care Claims</u>

If you are requesting pre-certification of an Urgent Care Claim, Allegiant Rx will respond to you and/or your provider with a determination by telephone as soon as possible taking into account the medical condition, but not later than 72 hours after receipt of the request. The determination will also be confirmed in writing.

If an Urgent Care Claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, or if it is improperly filed, Allegiant Rx will notify you and/or your provider as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim or of the proper procedures to be followed in filing a claim. You and/or your provider must provide the specified information within 48 hours of receiving notice. If the information is not provided within that time, your claim will be denied. Regarding an improperly filed claim, if the claim is not re-filed properly, it will not constitute a claim.

Notice of the decision will be provided no later than 48 hours after the Fund's utilization review provider receives the specified information.

For Pre-Service Claims

For properly filed Pre-Service Claims, you and/or your provider will be notified of a decision within 15 days from receipt of the claim unless additional time is needed. The time for response may be extended up to 15 days if necessary due to matters beyond the control of Allegiant Rx. You will be notified within the initial 15-day time period of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If an extension is needed because Allegiant Rx needs additional information from you, the extension notice will specify the information needed. In that case you and/or your provider will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be deemed to be denied, without further. During this period, the normal timeframes for making a decision on the claim will be suspended for either 180 days or the date you respond to the request (whichever is earlier). Allegiant Rx will then make a decision within 15 days of the date it receives the requested information and notify you of the determination.

If you or your provider improperly file a Pre-Service Claim, Allegiant Rx will notify you as soon as possible, but not later than 5 days after receipt of the claim, of the proper procedures to be followed in filing a claim. You will only receive notice of an improperly filed Pre-Service Claim if the claim includes (i) your name, and (ii) your specific medical condition or symptom. Unless the claim is re-filed properly, it will not constitute a claim.

For Concurrent Claims

The determination of a benefit with respect to a Concurrent Claim will be made by Allegiant Rx as soon as possible, but in any event early enough to allow you to have an appeal decided before the benefit is reduced or terminated.

Any request by a claimant to *extend* approved Urgent Care treatment will be acted upon by Allegiant Rx within 24 hours of receipt of the claim, provided the claim is received at least 24 hours prior to the expiration of the approved treatment. A request to extend approved treatment that does not involve urgent care will be decided according to pre-service or post-service timeframes, whichever applies.

How to Appeal a Denied Claim

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you, or your duly authorized representative, may request a review of the denial of a claim by the Board of Trustees by submitting a written request for review to the Fund Office within 180 days after you receive written notice of an Adverse Benefit Determination. You also have the right to (1) request to review all documents upon which the denial is based and (2) submit issues and comments in writing and any other material that supports your appeal.

If the Fund does not receive your written request for an appeal within 180 days of your receipt of the denial, you will lose your right to have your claim appealed, including your right to sue the Fund. The Fund provides for only one appeal to the Board of Trustees for any denied claim.

The Board of Trustees will review your claim appeal. The Board is not bound by the original Adverse Benefit Determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

If your claim was denied on the basis of a medical judgment (such as a determination that the prescription was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

<u>How to Ask for an Appeal</u>

Remember, your request for an appeal must be received within 180 days after you receive notice of a denied claim.

For Urgent, Pre-Service and Concurrent Claim Appeals

For Urgent, Pre-Service and Concurrent Claim Appeals, appeals generally should be made in writing to Fund. However, in certain circumstances such as Urgent Claim appeals where medical conditions exist that require an expedited review process, appeals may be made orally via telephone to the Fund Office at the telephone number on the front page of this SPD twenty four hours a day, seven days a week. All other calls <u>must</u> be made during normal business hours, which are 9:00 a.m. to 5:00 p.m., Monday through Friday, excluding holidays.

A sub-committee consisting of several appointed Trustees will review Urgent, Pre-Service and Concurrent Claim appeals.

For Post-Service Claim Appeals

For Post-Service claims, appeals must be made in writing to the Board of Trustees in care of the Fund Office and must be received within 180 days after you receive notice of a denied claim.

<u>Information to Which You are Entitled</u>

You have the right to review documents relevant to your claim. A document, record or other information is relevant if:

- it was relied upon by Allegiant Rx/ESI in making the decision;
- it was submitted, considered or generated (regardless of whether it was relied upon) in making the decision;
- it demonstrates compliance with the Fund's administrative processes for ensuring consistent decision-making; or
- it constitutes a statement of Fund policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical or vocational experts, if any, who gave advice to the Allegiant Rx/ESI on your claim, without regard to whether their advice was relied upon in deciding your claim.

<u>Timing of Notice of Decision of Appeal</u>

For Pre-Service or Concurrent Claim Appeals

You will be sent a notice of decision of the appeal within 30 days of receipt of the appeal by the Board of Trustees.

For Urgent Care Claim Appeals

You will be notified of a decision on your appeal, either orally or in writing (or both) within 24 hours of receipt of the appeal by the Board of Trustees or its sub-committee.

For Post-Service Claim Appeals

A decision will be made at the next regularly scheduled quarterly meeting of the Board of Trustees following receipt of your request for an appeal. However, if your request for an appeal is received within 30 days of the next regularly scheduled meeting, your request for an appeal will be considered at the second regularly scheduled meeting following receipt of your request.

In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on your appeal has been reached, you will be given written notice of the decision as soon as possible, but no later than 5 days after the decision has been reached.

Notice of Decision on Appeal

The decision on an appeal will be given to you in writing. The notice of a denial of an appeal will state:

- the specific reason for the denial;
- the particular provision in this SPD upon which the denial is based;
- a statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim and appeal, upon request and free of charge;
- if the denial was based on an internal Fund guideline or rule, a copy of the rule or guideline or a statement that it is available free of charge;
- if the denial is based on medical evidence, an explanation of the scientific or clinical judgment applied to the terms of the Fund; and
- a statement of your rights under Federal law.

External Appeals Process

When you are dissatisfied with a benefit denial by the Fund, in addition to the internal appeals process you may appeal a benefit decision outside the Fund.

a. Request for external review. You may request an external review in writing to the Fund Office within four (4) months after the date you received a notice of a full or partial denial of your internal appeal, including a denial of eligibility for benefits from the Fund.

b. Preliminary review. Within five (5) business days of receiving your written request for an external review, the Fund must complete a preliminary review of the request to determine if you were covered under the Fund at the time of service, if the denial was based on eligibility, if you exhausted the Fund's internal appeals process and if you have provided the necessary information for an external review.

   Within one business day of this review, the Fund must notify you that your request is (1) complete and is eligible for the external review, (2) complete but not eligible for an external review giving the reasons and contact information for the Employee Benefit Security Administration, or (3) eligible for review, but is not complete with a description of what additional information must be provided – you will have two days or until the end of the four month appeal period to provide the necessary information, whichever is longer.

c. Referral to Independent Review Organization. The Fund will assign your appeal to an independent review organization (IRO). The Fund is required to contract with three IROs and rotate appeals among them. The IRO must issue a decision within 45 days of the receipt of the appeal.

d. Expedited Review. If you have an Urgent Care appeal the external review process is expedited.

FUND INFORMATION

This section provides details regarding the administration of the Fund and special rights that you have as a Fund participant. The interests of Fund participants and their beneficiaries are protected by the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA sets standards for administering employee benefit Funds, including a requirement that certain information be disclosed to Fund participants and beneficiaries.

TYPE OF ADMINISTRATION

The "Fund" is group health Fund administered and maintained by a joint Board of Trustees consisting of three Labor Trustees and three Employer Trustees (names and addresses are below). The Board of Trustees has been designated as the Fund Administrator. The Board of Trustees is governed by the Agreement and Declaration of Trust establishing the Fund under which the Fund is maintained and in accordance with various Collective Bargaining Agreements. The Board of Trustees reserves the right to terminate, suspend, withdraw, amend, or modify the Fund in whole or in part at any time. You will be notified of a Fund amendment in a reasonable period of time.

THE NAME AND ADDRESS OF THE FUND

Teamsters Local No. 1150 Prescription Drug Benefit Fund
c/o Zenith American Solutions, Inc.
10 Technology Drive
P.O. Box 5817
Wallingford, CT 06492

The Fund number assigned by the Board of Trustees is 001.

The Employer Identification Number ("EIN") issued to the Fund by the Internal Revenue Service is 80-0499402.

FUND ASSETS

Benefits are provided from Fund assets which are held in trust for the purpose of providing benefits to covered participants and defraying reasonable administrative costs. The Fund's assets and reserves may be invested by the Board of Trustees or by investment managers or advisors selected by the Board of Trustees. In the event of a Fund termination, the assets of the Fund shall be applied to pay the obligations of the Fund. Any surplus shall be distributed by the trustees in a manner consistent with the purpose of the Fund. No part of the assets of the Fund shall revert to Sikorsky Aircraft, Corp, Lockheed Martin or any contributing employer or to the Teamsters Local No. 1150.

CONTRIBUTING EMPLOYERS

You may make a written request to the Fund Office for information as to whether a particular employer or employee organization is a contributing employer with respect to this Fund and, if so, you may request the address of that contributing employer.

REFERENCE TO COLLECTIVE BARGAINING AGREEMENTS

The Fund is maintained pursuant to various collective bargaining agreements that provide for the rate of employer contributions to the Fund, the type of work and areas of work for which contributions are payable and certain other terms governing contributions. A copy of the applicable collective bargaining agreement(s) may be obtained by employees upon payment of a reasonable charge by written request to the Fund Office and is also available for examination at the Fund Office.

TYPE OF FUND

This Fund provides Prescription Drug Benefits to eligible employees and their dependents ("Participants"). Such benefits are provided by the Fund on a self-insured basis. Circumstances that may result in disqualification, ineligibility or denial, loss, forfeiture or suspension of any benefits are fully described in this booklet. All current benefits provided by the Fund are set forth in this booklet.

SOURCE OF CONTRIBUTIONS TO FUND

Contributions to the Fund are made by Lockheed Martin Corporation at the rates established by Collective Bargaining Agreements with the Teamsters Local 1150 and other agreements with the Trustees.

NAMES AND ADDRESSES OF THE BOARD OF TRUSTEES

Mr. Rocco J. Calo, Co-Chairman
Teamsters Local Union No. 1150
150 Garfield Avenue
Stratford, CT 06615-7101

Ms. Deborah Johnson
Teamsters Local Union No. 1150
150 Garfield Avenue
Stratford, CT 06615-7101

Mr. John B. Santamaria
Teamsters Local Union No. 1150
150 Garfield Avenue
Stratford, CT 06615-7101

Mr. Michael Bogue, Co-Chairman
Sikorsky Aircraft Corp.
6900 Main Street P.O Box 9729
Stratford, CT 06615-9129

Ms. Melissa Wessells
Lockheed Martin Corporation
6801 Rockledge Drive
Bethesda, MD 20817

Ms. Kalyn Redlowsk
Sikorsky Aircraft Corp.
6900 Main Street P.O Box 9729
Stratford, CT 06615-9129

NAME AND ADDRESS OF THE PERSON DESIGNATED AS AGENT FOR SERVICE OF LEGAL PROCESS

David Leonardo
ZENITH AMERICAN SOLUTIONS, INC.
10 Technology Drive
Wallingford, CT 06492

In addition, legal process may be served upon any Fund Trustee at the address stated in the preceding item.

PLAN YEAR

All financial records of the Fund are kept on a fiscal year of September 1 to August 31.

APPEAL PROCEDURE

If a participant is denied in whole or in part any benefits under this Fund, as specified in Section 503 of the Employee Retirement Income Security Act of1974 ("ERISA"), remedies are available and are set forth in this SPD under the section entitled, "Adverse Benefit Determinations," above.

ERRONEOUS OVERPAYMENTS or MISREPRESENTATIONS or FRAUD

If you receive any benefits from the Fund to which you are not eligible, the Board of Trustees has the right to recover the amount of the overpayment from any party, including the party who received such erroneous payment, the party who is responsible for such erroneous payment or you. The Board of Trustees may make such recovery by any means it deems advisable, including, but not limited to, reducing future claim payments that you or your eligible dependents would otherwise receive by the amount of the overpayment.

NOTICE: If you receive any benefits as a result of false or misleading statements, including withheld information, you will be required to repay all amounts paid by the Fund and all the costs and expenses of collection, including compound interest in the amount of twelve percent (12%) per year, compounded monthly and attorneys' fees. The Trustees also may disqualify you and your dependents from further participation in the Fund.

NO VESTED BENEFITS

There is no vested right to any benefits under this Fund. The Board of Trustees reserves the right to terminate, suspend, or modify the Fund in whole or in part at any time. This means, among other things, that the Board of Trustees, in their sole discretion, from time to time, may change the level and type of benefits available under this Fund.

YOUR RIGHTS UNDER ERISA

As a participant in this Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Fund participants shall be entitled to:

1. Receive information about your benefits. You can:

   - Examine without charge, at the Fund Office, all documents governing the Fund, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Fund 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 Fund Office, copies of documents governing the operation of the Fund, 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 Fund's annual financial report. The Fund administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Continue Group Health Fund Coverage. You can continue health care coverage for yourself and/or your dependents if there is a loss of coverage under the Fund as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD at pages X through Y on the rules governing your COBRA continuation coverage rights.

<u>Prudent Actions by Fund Fiduciaries</u>

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

<u>Enforce Your Rights</u>

If your claim for benefits 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 Fund documents or the latest annual report from the Fund 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 Fund administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in Federal court. In addition, if you disagree with the Fund's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Fund fiduciaries misuse the Fund'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 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 this Fund, you should contact the Fund Office.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund Office, 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, NW, 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.

"Si usted no entiende o no puede leer ingles, entonces contacte a su oficina de Fundificacion para que le expliquen los beneficios de su Fund."

CONTINUATION OF COVERAGE UPON MILITARY SERVICE

The Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994 continues the protection of civilian job rights and benefits for veterans and members of reserve components of the armed services. Please see the Group Benefits Plan for Employees of Sikorsky Aircraft Corporation, a Lockheed Martin Company SPD.

FAMILY AND MEDICAL LEAVE ACT (“FMLA”)

The Family and Medical Leave Act of 1993 (“FMLA”) generally applies to employers with 50 or more employees. Please see the Group Benefits Plan for Employees of Sikorsky Aircraft Corporation, a Lockheed Martin Company SPD.

PRIVACY PRACTICES

Introduction

This section describes how medical information about you may be used and disclosed, how you can get access to this information and your rights under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). Please review it carefully.

The Fund is required by law to take reasonable steps to ensure the privacy of your Protected Health Information ("PHI"), as defined in this section, and to inform you about:

(1) the Fund's uses and disclosures of PHI;
(2) your privacy rights with respect to your PHI;
(3) the Fund's duties with respect to your PHI;
(4) your right to file a complaint with the Fund and with the Secretary of U.S. Department of Health & Human Services (“HHS”); and
(5) the person or office to contact for further information about the Fund's privacy practices.

The term “Protected Health Information” (PHI) includes all "Individually Identifiable Health Information" transmitted or maintained by the Fund, regardless of form (oral, written or electronic). The term “Individually Identifiable Health Information” means information that:

A. Is created or received by a health care provider, health Fund, employer or health care clearinghouse;
B. Relates to the past, present or future physical or mental health of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and
C. Identifies the individual, or reasonably could be used to identify the individual.

PHI Uses and Disclosures

Except as outlined below, uses and disclosures of your PHI will be made only with your written authorization, subject to your right to revoke such authorization. You may revoke an authorization at any time, provided your revocation is done in writing. You can not revoke your authorization regarding actions already taken by the Fund in reliance upon the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage.

<u>Uses and Disclosures Without Your Consent or Notice</u>

Required PHI Disclosures

The Fund must disclose your PHI without your consent or previous knowledge when required by law, provided that the use or disclosure complies with and is limited to the relevant requirements of such law.

- The Fund must disclose your PHI when required by the federal government to determine the Fund's compliance with the Privacy Standards.
- The Fund is required to release your PHI to you, with certain exceptions, upon your request.

Permitted Uses and Disclosures of Your PHI

The Fund is allowed to use and disclose your PHI without your consent or previous knowledge in order to facilitate your medical treatment, the payment of your medical treatment and health care operations necessary to run the Fund, but only to entities covered by the HIPAA privacy rules, or entities that agree to abide by the HIPAA privacy rules.

The following are the different ways the Fund may use and disclose your PHI:

- **For Treatment.** The Fund may disclose your PHI to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the Fund may advise an emergency room physician about the types of prescription drugs you currently take.

- **For Payment.** The Fund may use and disclose your PHI so claims for health care treatment, services, and supplies you receive from health care providers may be paid according to the Fund's terms. For example, the Fund may receive and maintain information about surgery you received to enable the Fund to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf.

- **For Health Care Operations.** The Fund may use and disclose your PHI to enable it to operate or operate more efficiently or make certain all of the Fund's Participants receive their health benefits. For example, the Fund may use your PHI for case management or to perform population-based studies designed to reduce health care costs. In addition, the Fund may use or disclose your PHI to conduct compliance reviews, audits, actuarial studies, and/or for fraud and abuse detection. The Fund may also combine health information about many Fund participants and disclose it to an employer or group of employers in summary fashion so they can decide what coverage the Fund should provide. The Fund may remove information that identifies you from health information disclosed to the employer so it may be used without the employer learning who the specific participants are.

- **To an Employer (or group of employers).** The Fund may disclose your PHI to designated personnel of your employer so they can carry out their Fund-related administrative functions, including the uses and disclosures described in this notice. However, these individuals must protect the privacy of your health information and ensure it is used only as described in this notice or as permitted by law. Unless authorized by you in writing, your health information will not be used for any employment-related actions and decisions or in connection with any other employee benefit Fund.

- **To a Business Associate.** Certain services may be provided to the Fund by third party administrators known as "business associates." For example, the Fund may input information about your health care treatment into an electronic claims processing system maintained by the Fund's business associate so your claim may be paid. In so doing, the Fund will disclose your PHI to its business associate so it can perform its claims payment function. However, the Fund will require its business associates, through contract, to appropriately safeguard your health information.

The Fund is also allowed to use and disclose your PHI for purposes of public health activities, including disclosures to:

(a) an appropriate government authority authorized by law to receive reports of child abuse or neglect,
(b) the U.S. Food and Drug Administration (FDA) regarding the quality, safety or effectiveness of an FDA-regulated product or activity, and
(c) a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law.

In addition, the Fund may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Uses and Disclosures That Require That You Be Given Notice Only

Disclosures to Governmental Agencies When the Fund Believes that You are the Victim of Abuse

The Fund may disclose your PHI to a government authority, including a social service or protective services agency, if the Fund reasonably believes you to be a victim of abuse, neglect, or domestic violence. In such case, the Fund will promptly inform you that such a disclosure has been or will be made unless (i) the Fund believes that informing you would place you at risk of serious harm or (ii) the Fund would be informing your personal representative, and the Fund believes that your personal representative is responsible for the abuse, neglect or other injury, and that informing such person would not be in your best interests.

For the purposes of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure generally may be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

Disclosures to Governmental Agencies for Health Care Oversight

The Fund may disclose your PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of: (i) the health care system, (ii) government benefit programs for which health information is relevant to beneficiary eligibility, (iii) entities subject to government regulatory programs for which health information is needed to determine compliance with program standards, or (iv) entities subject to civil rights laws for which health information is needed to determine compliance.

Disclosures to Courts or Administrative Agencies

The Fund may disclose your PHI in the course of a judicial or administrative proceeding in response to an order of a court or administrative tribunal, provided that the Fund discloses only the PHI expressly authorized by such order, or in response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court or administrative tribunal if certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Fund that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection,

and the time to object has expired and either no objections were raised or any objections were resolved in favor of disclosure by the court or tribunal.

Disclosures to Law Enforcement Agencies for Law Enforcement Purposes

The Fund may disclose PHI as required by law, including laws that require the reporting of certain types of wounds. Also, the Fund may disclose PHI in compliance with (i) a court order, court-ordered warrant, or a subpoena or summons issued by a judicial officer, (ii) a grand jury subpoena, or (iii) an administrative request, including an administrative subpoena or summons, a civil or authorized investigative demand, provided certain conditions are satisfied. PHI may be disclosed for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Fund may disclose your PHI in response to a law enforcement official's request if you are, or are suspected to be, a victim of a crime. Further, the Fund may disclose your PHI if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Fund's premises.

The Fund may disclose PHI to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

Disclosures for Research Purposes

The Fund may use or disclose PHI for research, when consistent with applicable law and standards of ethical conduct. The Fund may use or disclose PHI if the Fund, in good faith, believes the use or disclosure: (i) is necessary to prevent or lessen a serious and imminent threat to health or safety of a person or the public and is to person(s) able to prevent or lessen the threat, including the target of the threat, or (ii) is needed for law enforcement authorities to identify or apprehend an individual, provided certain requirements are met.

Disclosures for Workers' Compensation Claims

The Fund may use or disclose PHI to the extent necessary to comply with Workers' Compensation or other similar programs established by law.

Uses and Disclosures That Require That You Be Given An Opportunity To Agree Or Disagree Prior To The Disclosure

Disclosures to Others Involved in Your Care When You Are Present

The Fund may disclose your PHI to a family member, other relative, close personal friend of yours or any other person you identify, but only the PHI directly relevant to such person's involvement with your care or payment for your health care when

you are present for, or otherwise available prior to, a disclosure and you are able to make health care decisions, if:

- You agree (you may agree or disagree orally to such a disclosure);
- You have the opportunity to object to the disclosure and fail to do so; or
- The Fund infers from the circumstances based upon professional judgment that you do not object to the disclosure.

Disclosures to Others Involved in Your Care in an Emergency

In an Emergency or if you are incapacitated, the Fund may determine that disclosure is in your best interest, in its professional judgment, and disclose only your PHI that is directly relevant to the person's involvement with your health care even if you are not present, or you can not agree or object to the disclosure because of your incapacity or the circumstances.

Uses and Disclosures That Require Your Written Authorization

Psychotherapy Notes

Your written authorization generally will be obtained before the Fund will use or disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session.

Your Privacy Rights

You Have the Right to Request Restrictions on PHI Uses and Disclosures

You may request that the Fund restrict its uses and disclosures of your PHI to carry out treatment, payment or health care operations. You may also request restrictions of disclosures the Fund makes to someone involved in your care or for the payment for your care. However, the Fund is not required to agree to your requested restrictions.

You or your personal representative will be required to request restrictions on uses and disclosures of your PHI in writing. Such requests should be addressed to the Fund's Privacy Officer, identified at the beginning of this SPD.

If the Fund agrees to a requested restriction, the Fund may not use or disclose PHI in violation of such restriction, except that, if you requested a restriction and later are in need of emergency treatment and the restricted PHI is needed to provide the emergency treatment, the Fund may use the restricted PHI, or it may disclose such information to a health care provider, to provide such treatment to you. If restricted PHI is disclosed to a health care provider for emergency treatment, the Fund must request that such health care provider not further use or disclose the information.

If the Fund agrees to a restriction, it will document the restriction by maintaining a written or electronic record of the restriction. The record of the restriction will be retained for six years from the date of its creation or the date when it last was in effect, whichever is later.

A restriction agreed to by the Fund is not effective to prevent uses or disclosures when required by the Secretary of HHS to investigate or determine the Fund's compliance with the Privacy Standards or uses or disclosures that are otherwise required by law.

The Fund may terminate its agreement to a restriction, if:

- You agree to or request the termination in writing;
- You orally agree to the termination and the oral agreement is documented; or
- The Fund informs you that it is terminating its agreement to a restriction, except that such termination is only effective with respect to PHI created or received after the Fund has informed you of the termination.

You Have the Right to Request Confidential Communications of PHI

You may request to receive communications of PHI from the Fund by alternative means or at alternative locations. For example, you can ask that the Fund send you explanation of benefit (EOB) forms about your benefit claims to a specific address.

You or your personal representative will be required to request confidential communications of your PHI in writing. Such requests should be addressed to the Fund's Privacy Officer, identified at the beginning of this SPD.

The Fund will accommodate all such reasonable requests. However, the Fund may condition the provision of a reasonable accommodation on:

- Information as to how payment, if any, will be handled; and
- Specification by you of an alternative address or other method of contact.

You Have the Right to Inspect and Copy Your PHI

You have the right to inspect and copy your PHI, including an accounting of disclosures of PHI made by the Fund. This includes information about your Fund eligibility, claims and appeal records, and billing records. You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Fund maintains PHI in the designated record set.

"**Designated Record Set**" means a group of records maintained by or for a health Fund that is enrollment, payment, claims adjudication and case or medical management record systems maintained by or for a health Fund; or used in whole or in part by or for the health Fund to make decisions about individuals. Information used for quality control

or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The Fund will act on a request for access no later than 30 days after receipt of the request. However, if the request is for access to PHI that is not maintained or accessible to the Fund on-site, the Fund must take action no later than 60 days from the receipt of such request. The Fund must take action as follows: if the Fund grants the request, in whole or in part, the Fund must inform you of the acceptance and provide the access requested. However, if the Fund denies the request, in whole or in part, the Fund must provide you with a written denial. If the Fund cannot take action within the required time, the Fund may extend the time for such action by no more than 30 days if the Fund, within the applicable time limit, provides you with a written statement of the reasons for the delay and the date by which it will complete its action on the request.

The Fund will provide you with access to the PHI in the form or format requested if it is readily producible in such form or format; or, if it is not, in a readable hard copy form or such other form or format as agreed to between you and the Fund. The Fund may provide you with a summary of the PHI requested, in lieu of providing access to the PHI or may provide an explanation of the PHI to which access has been provided in certain circumstances. The Fund will arrange with you for a convenient time and place to inspect or obtain a copy of the PHI, or mail a copy of the PHI at your request. If you request a copy of PHI or agree to a summary or explanation of PHI, the Fund may impose a reasonable, cost-based fee.

If the Fund denies access to PHI in whole or in part, the Fund will, to the extent possible, give you access to any other PHI requested, after excluding PHI as to which the Fund has grounds to deny access. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, if applicable, a statement of your review rights, including a description of how you may exercise those review rights and a description of how you may complain to the Fund or to the Secretary of the HHS. If you request review of a decision to deny access, the Fund will refer the request to a designated licensed health care professional for review. The reviewing official will determine, within a reasonable period of time, whether to deny the access requested. The Fund will promptly provide you with written notice of that determination.

If the Fund does not maintain the PHI that is the subject of your request for access, and the Fund knows where the requested information is maintained, the Fund will inform you where to direct the request for access.

You or your personal representative will be required to request access to your PHI in writing. Such requests should be addressed to the Fund's Privacy Officer, identified at the beginning of this SPD.

<u>You Have the Right to Amend Your PHI</u>

If you believe that health information the Fund has about you is incorrect or incomplete, you can ask the Fund to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. The Fund may deny your request for amendment if it determines that the PHI or record that is the subject of the request:

- Was not created by the Fund, unless you provide a reasonable basis to believe that the originator of PHI is no longer available to act on the requested amendment;
- Is not part of the designated record set;
- Would not be available for your inspection under the Privacy Standards; or
- Is accurate and complete.

The Fund has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Fund is unable to comply within that deadline provided that the Fund, within the original 60-day time period, gives you a written statement of the reasons for the delay and the date by which it will complete its action on the request. If the Fund accepts the requested amendment, the Fund will make the appropriate by, at a minimum, identifying the records in the designated record set that are affected by the amendment and appending or otherwise providing a link to the location of the amendment. The Fund will timely inform you that the amendment is accepted and obtain your identification of and agreement to have the Fund notify the relevant persons with which the amendment needs to be shared as provided in the Privacy Standards.

If the request is denied in whole or part, the Fund must provide you with a written denial that (i) explains the basis for the denial, (ii) sets forth your right to submit a written statement disagreeing with the denial and how to file such a statement, (iii) states that, if you do not submit a statement of disagreement, you may request that the Fund provide your request for amendment and the denial with any future disclosures of the PHI that is the subject of the amendment, and (iv) includes a description of how you may complain to the Fund or to the Secretary of HHS. The Fund may reasonably limit the length of a statement of disagreement. Further, the Fund may prepare a written rebuttal to a statement of disagreement, which will be provided to you.

The Fund must, as appropriate, identify the record or PHI in the designated record set that is the subject of the disputed amendment and append or otherwise link your request for an amendment, the Fund's denial of the request, your statement of disagreement, if any, and the Fund's rebuttal, if any, to the designated record set. If a statement of disagreement has been submitted, the Fund will include the above-referenced material, or, at the Fund's election, an accurate summary of such information, with any subsequent disclosure of the PHI to which the disagreement relates. If you do not submit a written statement of disagreement, the Fund must include your request for amendment and its denial, or an accurate summary of such information with any subsequent disclosure of the PHI only if requested by you.

You or your personal representative will be required to request amendment to your PHI in a designated record set in writing. Such requests should be addressed to the Fund's Privacy Officer, identified at the beginning of this SPD.

All requests for amendment of PHI must include a reason to support the requested amendment.

<u>You Have the Right to Receive an Accounting of PHI Disclosures</u>

At your request, the Fund will provide you with an accounting of disclosures by the Fund of your PHI during the six (6) years prior to the date on which the accounting is requested. However, such accounting need not include PHI disclosures made:

(a) to carry out treatment, payment or health care operations;
(b) to individuals about their own PHI;
(c) incident to a use or disclosure otherwise permitted or required by the Privacy Standards;
(d) pursuant to an authorization;
(e) to certain persons involved in your care or payment for your care;
(f) to notify certain persons of your location, general condition or death;
(g) as part of a "Limited Data Set" (as defined in the Privacy Standards), which largely relates to research purposes; or
(h) prior to the compliance date of April 14, 2003.

You may request an accounting of disclosures for a period of time of up to six years prior to the date of the request.

The accounting will include disclosures of PHI that occurred during the six years (or such shorter time period, if applicable) prior to the date of the request for an accounting, including disclosures to or by business associates of the Fund. Except as otherwise provided below, for each disclosure, the accounting will include:

(a) The date of the disclosure;
(b) The name of the entity or person who received the PHI and, if known, the address of such entity or person;
(c) A brief description of the PHI disclosed; and
(d) A brief statement of the purpose of the disclosure that reasonably informs you of the basis for the disclosure, or, in lieu of such statement, a copy of a written request for disclosure.

If during the period covered by the accounting, the Fund has made multiple disclosures of PHI to the same person or entity for a single purpose, the accounting may, with respect to such multiple disclosures, provide the above-referenced information for the first disclosure; the frequency, periodicity or number of the disclosures made during the accounting period; and the date of the last disclosure.

If during the period covered by the accounting, the Fund has made disclosures of PHI for a particular research purpose for 50 or more individuals, the accounting may, with respect to such disclosures for which your PHI may have been included, provide certain information as permitted by the Privacy Standards. If the Fund provides an accounting for such research disclosures, and if it is reasonably likely that your PHI was disclosed for such research activity, the Fund shall, at your request, assist in contacting the entity that sponsored the research and the researcher.

If the accounting cannot be provided within 60 days after receipt of the request, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Fund will charge a reasonable, cost-based fee for each subsequent accounting unless you withdraw or modify the request for a subsequent accounting to avoid or reduce the fee.

You or your personal representative will be required to request an accounting of your PHI disclosures in writing. Such requests should be addressed to the Fund's Privacy Officer, identified at the beginning of this SPD. Your request must state a time period, which is subject to the limitations described in the first paragraph of this section.

You Have the Right To Receive an Additional Paper Copy of This Notice Upon Request

You have a right to obtain an additional paper copy of this Notice upon request. To request an additional paper copy of this Notice, contact the Fund's Privacy Officer, identified at the beginning of this SPD.

A Note about Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may include, but is not limited to, the following:

(a) a power of attorney for health care purposes, notarized by a notary public;
(b) a court order of appointment of the person as the conservator or guardian of the individual; or
(c) an individual who is the parent of a minor child under eighteen years of age.

The Fund retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors under eighteen years of age.

The Fund's Duties

Notice

The Fund is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices with respect to PHI.

This Notice is effective beginning on April 14, 2003, and the Fund is required to comply with its terms. However, the Fund reserves the right to change the terms of this Notice and to make the new revised notice provisions effective for all PHI that it maintains, including any PHI created, received or maintained by the Fund prior to the date of the revised notice. If a privacy practice is changed, a revised version of this Notice will be provided to all individuals then covered by the Fund. If agreed upon between the Fund and you, the Fund will provide you with a revised Notice electronically. Otherwise, the Fund will mail a paper copy of the revised Notice to your home address. In addition, the revised Notice will be maintained on any web site maintained by the Fund to provide information about its benefits.

Any revised version of this Notice will be distributed within 60 days of any material change to the uses or disclosures, the individual's rights, the duties of the Fund or other privacy practices stated in this Notice. Except when required by law, a material change to any term of this Notice may not be implemented prior to the effective date of the revised notice in which such material change is reflected.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Fund will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

(a) disclosures to or requests by a health care provider for treatment;
(b) disclosures made to you;
(c) disclosures made to the Secretary of HHS;

(d) uses or disclosures that are required by law;
(e) uses or disclosures that are required for the Fund's compliance with the Privacy Standards; and
(f) uses or disclosures made pursuant to an authorization.

De-Identified Information

This Notice does not apply to information that has been de-identified. De-identified information is health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. It is not individually identifiable health information.

In addition, the Fund may use or disclose "summary health information" to the Board of Trustees for obtaining premium bids or modifying, amending or terminating the group health Fund. Summary health information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Fund sponsor has provided health benefits under a group health Fund, and from which identifying information has been deleted in accordance with the Privacy Standards.

Your Right to File a Complaint with The Fund or The HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Fund. Any complaint must be in writing and addressed to the Fund's Privacy Officer, identified at the beginning of this SPD.

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services, by writing to him or her at the following address: The Hubert H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201.

The Fund will not retaliate against you for filing a complaint.

THE PRIVACY OFFICER FOR MORE INFORMATION

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Fund's Privacy Officer, identified at the beginning of this SPD.

Conclusion

PHI use and disclosure by the Fund is regulated by a federal law known as HIPAA. You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This Notice attempts to summarize the Privacy Standards. The Privacy Standards will supersede any discrepancy between the information in this Notice and the Privacy Standards.