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

PLAN A
SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT

MEDICAL, PRESCRIPTION DRUG, DENTAL, VISION, DEATH AND DISMEMBERMENT BENEFITS FOR ACTIVE PLAN A PARTICIPANTS AND ELIGIBLE DEPENDENTS

REVISED JULY 1, 2017

QUICK REFERENCE CHART

Mailing addresses are listed on page 104 of this booklet.

PLAN ADMINISTRATIVE OFFICE	
• **Questions about eligibility, hour banks, or general information** • **Questions about death benefits or accidental death and dismemberment benefits** • **Summaries of Benefits and Coverage (SBCs)** • **Questions about Self-Pay or COBRA** • **HIPAA Privacy Notice, Privacy & Security Officers** • **Steps to take if you are unable to work due to illness or injury**	**Toll free (800) 947-4338** **or visit the Plan's website: www.sheetmetalsam.org**

FEE-FOR-SERVICE PPO MEDICAL OPTION	
• **Questions about preferred providers, contact Anthem** • **Pre-authorization requests (an Emergency does not require pre-authorization, just notice to Anthem)**	**Toll free (877) 359-9644** **To locate a preferred provider call or go to www.anthem.com** **For pre-authorization toll free** **In California (800) 274-7767** **In Nevada (800) 336-7767** **For pre-authorization of substance abuse rehabilitation toll free (800) 828-3939**
• **Questions about medical benefits or claims, contact the Plan Administrative Office** • **Replacement of ID cards, general assistance, contact the Plan Administrative Office**	**Toll free (800) 947-4338**
• **Questions about Prescriptions, Specialty Drugs, and pre-authorization of certain prescription drugs, contact Express Scripts**	**Toll free (800) 349-3780** **Call or visit the website: www.express-scripts.com**

HMO/EPO OPTIONS – Questions about providers, benefits or claims; replacement ID cards	
• **Kaiser HMO - California**	**Toll free (800) 464-4000 or www.kp.org**
• **UnitedHealthcare HMO - California**	**Toll free (800) 624-8822 or www.myuhc.com**

• **Health Net HMO - California**	**Toll free (800) 522-0088 or www.healthnet.com**
• **Health Plan of Nevada (HPN) HMO - Nevada**	**Toll free (800) 777-1840 or www.healthplanofnevada.com**
• **UnitedHealthcare EPO - Nevada**	**Toll free (800) 377-5154 or www.myuhc.com**
• **Hometown Health HMO - Nevada**	**Toll free (800) 336-0123 or www.hometownhealth.com**

DENTAL COVERAGE – Questions about providers, benefits or claims; replacement ID cards	
Delta Dental (DMO or PPO Options)	**DeltaCare USA DMO: Toll free (800) 422-4234** **Delta DPPO: Toll free (800) 765-6003** **www.deltadentalins.com**

VISION COVERAGE – Questions about providers, benefits or claims	
Anthem Blue Cross Blue View Vision benefits	**Toll Free (866) 723-0515 or www.anthem.com**

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

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

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

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

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

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

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

Dear Active Plan A Participant:

We are pleased to present this new Summary Plan Description and Plan Document ("SPD"), which includes the eligibility rules for all active Plan A coverages, detailed descriptions of the medical and prescription drug benefits under the Fee-For-Service PPO Medical plan, and death and dismemberment benefits. Also included in the inside front pocket of this booklet are summaries of the HMO benefits, the dental benefits provided by Delta Dental, and the vision care benefits provided by Anthem Blue Cross.

The HMOs, Delta Dental, and Anthem Blue View Vision issue their own benefit booklets describing their insured benefits, which contain a more complete description of their coverage and how to obtain services. You should keep those booklets in the inside front or back pocket of this booklet. If you need a copy of a particular benefit booklet, please contact the Administrative Office at the above address or telephone number.

The Health Plan also provides a separate health care plan for active eligible sheet metal workers designated as Plan B Participants. If you are not sure of your plan designation, you should check your collective bargaining agreement or contact the Administrative Office.

Please take some time to review this SPD so you will be familiar with the rules of the Plan and the benefits available to you. Should you have any questions about eligibility or benefits, please refer to the Quick Reference Chart at the beginning of this booklet for the telephone numbers and website addresses you should use to get the answers you are seeking.

Sincerely,

THE BOARD OF TRUSTEES

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For dental coverage, please refer to your Delta Dental booklet. For vision care coverage, please refer to your Anthem Blue Cross Blue View Vision brochure. For HMO coverage, please refer to the applicable HMO evidence of coverage booklet. You should keep these booklets and brochure in the inside front or back cover of this booklet for easy reference.

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

PLAN A OVERVIEW

Below is an overview of:

- **Eligibility for Plan A**
- **Benefit Options under Plan A**
- **Summary of Benefits under Plan A's Fee-For-Service PPO Medical Option**
- **How to File a Claim**

For a more complete description of eligibility requirements and Plan A benefits, please refer to the following Chapters of this booklet (these are named in the preceding Table of Contents). If you are enrolled in an HMO or EPO, please refer to the benefit booklet issued by the HMO or EPO. For a complete description of dental coverage and vision coverage, please refer to the benefit booklets issued by Delta Dental (for dental) and Anthem Blue Cross (for vision).

NOTE: Capitalized terms used in this SPD have a precise meaning (for example, "Medically Necessary," "Emergency," or "Extended Care Facility"). To be sure you understand the meaning of capitalized terms, please refer to the Glossary which starts immediately after Chapter 8 of this booklet.

The eligibility rules that apply to all options offered under Plan A are contained in Chapter 1 of this booklet.

Overview of Eligibility	
Type of Participant	**Eligibility Requirement**
Active bargaining unit Sheet Metal Worker ***Refer to Chapter 1 for details, including special provisions for disabled participants, shareholders of a corporation, members of an LLC, and participants who are working for a new Contributing Employer.***	**Initial Eligibility**: Submit your properly completed enrollment forms when due, and have 240 hours worked for Contributing Employers in up to two consecutive calendar months. Coverage will then begin on the first day of the **second** calendar month following the date the 240 hours requirement is met. **Ongoing Eligibility**: Eligibility for benefits is continued on a month-to-month basis, and is determined by the number of hours worked for a Contributing Employer. 120 hours worked equals 1 month of coverage. There is a full month between work month and coverage month. All hours worked are credited to your "Hour Bank," up to a maximum equivalent to six months of coverage. 120 hours is deducted from your Hour Bank on the first day of each calendar month, for that month's coverage.

Overview of Eligibility	
Self-pay participants (unemployed, disabled, or COBRA participants) ***Refer to Chapter 1 for details, including application and self-payment deadlines and maximum coverage periods.***	Submit your properly completed enrollment forms when due, and submit the required monthly self-payments when due. Coverage is provided for a limited duration. The Administrative Office does NOT send bills or reminders. You are responsible for submitting the appropriate payment by the due date.
Dependents – legal spouse and children to age 26 (through age 18 for death benefits) ***Refer to Chapter 1 for details, including special extensions for totally disabled children***	Must be listed on the enrollment forms and proof of dependency documentation must be submitted when due (including upon subsequent request); dependents are generally eligible during the period that the participant to whom they are related is eligible. **Your newly acquired dependent must be properly enrolled within 31 days following the date you acquired the dependent in order to avoid a delay in the effective date of coverage.**

Overview of Medical Options and Additional Welfare Benefits	
Benefit	**Description**
Medical Options (eligible dependents can only be enrolled under the benefit option that covers the active participant)	**You may choose one of these applicable Options:** ***In California –*** • Fee-For-Service PPO Medical Option • Kaiser HMO • UnitedHealthcare HMO • Health Net HMO ***In Nevada –*** • Fee-For-Service PPO Medical Option • UnitedHealthcare EPO • Health Plan of Nevada (HPN) HMO • Hometown Health HMO (Northern Nevada only) ***In Other States –*** • Fee-For-Service PPO Medical Option

Overview of Medical Options and Additional Welfare Benefits	
Dental Coverage	***In California and Nevada –*** • DeltaCare USA DMO *The Delta Dental PPO option is available **only** if you live outside Delta's DMO service area or you have been continuously covered under the Delta Dental PPO option since June 30, 2016.* ***In Other States –*** • Delta Dental PPO Option
Vision care coverage	Vision care coverage provided by Anthem Blue Cross Blue View Vision In-network: $15 copay for exam; out-of-network: scheduled allowances apply Exam and lenses available once every 12 months and frame available once every 24 months
Death benefits on life of:	• Participant: $20,000 coverage • Spouse: $2,000 coverage • Children (birth through age 18): $2,000 coverage each
Accidental death and dismemberment benefits (participants only)	Up to $20,000 coverage, depending on type of loss

FEE-FOR-SERVICE PPO MEDICAL OPTION SUMMARY
(for those who elect this option)

All benefits listed under this Fee-For Service PPO Medical Option section are subject to the Deductible and Out-of-Pocket Maximum (unless otherwise stated).

If you use the services of a PPO Provider Hospital, Physician, laboratory, or other health care professional, your out-of-pocket expenses will be significantly less. If the services were available from a PPO Provider but were provided by a non-PPO Provider, your deductible will be higher and the percentage payable by Plan A will be less than what it would be had a PPO Provider been used.

All claims are subject to retrospective review by an independent medical consultant to determine if the claim is for Covered Services as defined in the Glossary.

BENEFITS	**COVERAGE AMOUNT**
Calendar Year Medical Deductible	The deductible does **not** apply to benefits for - ➢ birthing centers ➢ obstetrical care by nurse-midwives ➢ most preventive care when rendered by a PPO provider ➢ treatment of accidental injury within 72 hours of the accident
PPO Provider	$300 per person per calendar year; maximum of 3 deductibles per family
Non-PPO Provider	$600 per person per calendar year; maximum of 3 deductibles per family
Calendar Year Out-of-Pocket Maximum on Allowable Charges *(including the deductible, member coinsurance and copayments)*	Percentage payable increases to 100% of Allowable Charges once the Out-of-Pocket Maximum is reached during a calendar year. There is a separate Out-of-Pocket Maximum for outpatient prescription drugs (page 58).
PPO Provider	$3,400 per person per calendar year; $6,800 maximum per family
Non-PPO Provider	None (except non-PPO benefits for Hospital Emergency room care are the same as PPO benefits)
Overall Lifetime Maximum	None

BENEFITS	**COVERAGE AMOUNT**
PPO Hospital	
Inpatient	75% of Allowable Charges
Outpatient	
Surgical Care	75% of Allowable Charges
Emergency Room Care *The condition must meet the Plan's definition of an Emergency - see Glossary*	First $75 paid by participant in addition to the Medical Deductible if applicable, then coverage is 75% of Allowable Charges (the $75 is waived if you are admitted as an inpatient from the emergency room)
Other Covered Services	75% of Allowable Charges
Non-PPO Hospital	
Inpatient	50% of Allowable Charges
Outpatient	
Surgical Care	50% of Allowable Charges
Emergency Room Care *The condition must meet the Plan's definition of an Emergency-see Glossary*	First $75 paid by participant in addition to the Medical Deductible if applicable, then coverage is 75% of Allowable Charges (the $75 is waived if you are admitted as an inpatient from the emergency room)
Other Covered Services	50% of Allowable Charges
Ambulatory Center *(Surgicenter)*	
PPO Provider	75% of Allowable Charges
Non-PPO Provider	50% of Allowable Charges
Physician – Surgery and Hospital, Office or Other Visits	
PPO Physician	75% of Allowable Charges
Non-PPO Physician	50% of Allowable Charges
Diagnostic X-Ray, Laboratory and Scans *(Outpatient)*	
PPO Provider	75% of Allowable Charges
Non-PPO Provider	50% of Allowable Charges
Extended Care Facility or Rehabilitation Facility (*60 days maximum per calendar year)*	
PPO Provider	75% of Allowable Charges
Non-PPO Provider	50% of Allowable Charges
Home Health Care *(including nursing care by a Registered Nurse or Licensed Vocational Nurse only)*	
PPO Provider	75% of Allowable Charges
Non-PPO Provider	50% of Allowable Charges

NOTE: At least 72 hours before you go to the Hospital or Ambulatory Center (Surgicenter), or obtain durable medical equipment, nursing care or other home health care, it is recommended that you call for pre-authorization by dialing (800) 274-7767 or in Nevada, (800) 336-7767. For Emergency admissions, the call should be made within 48 hours after admission.

BENEFITS	**COVERAGE AMOUNT**
Preventive Care Services (*see page 49 for definition of Preventive Care Services)* PPO Provider Non-PPO Provider	 100% of Allowable Charges, deductible waived 50% of Allowable Charges
Psychiatric Care PPO Provider Non-PPO Provider	 75% of Allowable Charges 50% of Allowable Charges
Substance Abuse Care ***(You should call (800) 828-3939 prior to any treatment)*** PPO Provider Non-PPO Provider	 75% of Allowable Charges 50% of Allowable Charges
Transplants *(You must call (800) 274-7767 or in Nevada, (800) 336-7767 prior to the pre-transplant evaluation)*	75% of Allowable Charges when under case management and pre-authorization is obtained; **no benefits if not under case management or pre-authorization is not obtained**; covered donor expenses are limited to a maximum payment of $50,000 per transplant
Hospice Care PPO or Non-PPO Provider	 75% of Allowable Charges
Maternity Care (coverage for delivery is provided only to female participant or legal spouse)	Hospital and medical services and supplies are covered on the same basis as for an illness except: Routine prenatal care and breast feeding support, equipment and supplies are covered as a Preventive Care Service for all eligible females Birthing Center services are covered at 100% of Allowable Charges up to a maximum payment of $1,500, deductible waived Certified Nurse-Midwife services are covered at 100% of Allowable Charges, deductible waived
Durable Medical Equipment, Corrective Appliances and Prosthetics *(Pre-authorization Recommended)* PPO Provider Non-PPO Provider	 75% of Allowable Charges 50% of Allowable Charges

NOTE: At least 72 hours before you go to the Hospital or Ambulatory Center (Surgicenter), or obtain durable medical equipment, nursing care or other home health care, it is recommended that you call for pre-authorization by dialing (800) 274-7767 or in Nevada, (800) 336-7767. For Emergency admissions, the call should be made within 48 hours after admission.

BENEFITS	**COVERAGE AMOUNT**
Chiropractic Care PPO or Non-PPO Provider	100% of Allowable Charges up to a maximum payment of $40 per visit
Physical Therapy *(Short-term physical therapy is generally limited to 32 visits within a 6 month period, including cardiac rehabilitation)*	
PPO Provider	75% of Allowable Charges
Non-PPO Provider	50% of Allowable Charges
Speech Therapy PPO Provider Non-PPO Provider	 75% of Allowable Charges 50% of Allowable Charges
Vision Therapy *(therapy must be in lieu of surgery - pre-authorization recommended)* PPO or Non-PPO Provider	100% of Allowable Charges up to a maximum payment of $45 per visit
Hormone Therapy *(services provided to children must be rendered by a Board-Certified Pediatric Endocrinologist – pre-authorization recommended)* PPO Provider Non-PPO Provider	 75% of Allowable Charges 50% of Allowable Charges
Acupuncture PPO or Non-PPO Provider	100% of Allowable Charges up to a maximum payment of $35 per visit
Professional Ambulance Service PPO or Non-PPO Provider	75% of Allowable Charges up to a maximum payment per trip of $1,000 for ground transportation and $10,000 plus $100 per mile for air ambulance
Other Covered Services PPO Provider Non-PPO Provider	 75% of Allowable Charges 50% of Allowable Charges

BENEFITS	COVERAGE AMOUNT
OTHER BENEFITS UNDER THE FEE-FOR-SERVICE PPO MEDICAL OPTION	All benefits listed under "OTHER BENEFITS" are not subject to the Fee-For-Service PPO Medical Deductible and Out-of-Pocket Maximum *(a separate Out-of-Pocket Maximum applies to Prescription Drugs)*
Hearing Aids *(for those who elect the Fee-For-Service PPO Medical option)*	No deductible or out-of-pocket maximum applies;100% of Allowable Charges up to a maximum payment of $1,000 for each device; one hearing aid device for each ear is covered once during any three year period
Outpatient Prescription Drugs *(for those who elect the Fee-For-Service PPO Medical option)*	No deductible applies
Calendar Year Out-of-Pocket Maximum on Co-Payments	$3,200 per person per calendar year; $6,400 family maximum
Participating Retail Pharmacies *(30 day supply limit)*	$10 co-payment per generic drug $30 co-payment per preferred brand name drug $45 co-payment per other brand name drug
Participating Mail Service Pharmacy *(90 day supply limit)*	$15 co-payment per generic drug $45 co-payment per preferred brand name drug $68 co-payment per other brand name drug

FILING CLAIMS

Information on how to file claims is included at the end of each of the Chapters describing individual benefits. For information on what to do if you disagree with the decision made about your claim, see "Claims Review Procedures" in Chapter 8, "Other Important Information."

CHAPTER 1 - ELIGIBILITY RULES FOR COVERAGE

The eligibility rules outlined in this booklet apply to all the benefit options and coverage provided by or through Plan A, including all the medical, dental, and vision care coverages.

In this Chapter you'll find:

- **General information on Plan A options**
- **Enrollment procedures**
- **How to establish and maintain eligibility**
- **When eligibility terminates**
- **Transfer of coverage from Plan A to Plan B or vice-versa**
- **Eligible dependents**
- **Coverage extensions (family and medical leave, military leave, self-pay and COBRA continuation coverage)**

GENERAL INFORMATION

The following benefit options are offered to eligible participants by Plan A:

Medical

- a Fee-For-Service PPO Medical Option provided directly by the Plan. If you are enrolled in this option, you are also eligible for the Prescription Drug Benefits described in this booklet.

- HMO or EPO medical options – you and your dependents must live within an HMO's or EPO's applicable service area to be eligible to enroll in the HMO or EPO. If you are enrolled in an HMO or EPO, your prescription drug coverage is also provided by the HMO or EPO.

Dental

- a DMO option provided by Delta Dental (DeltaCare USA DMO).

- a PPO Dental option provided by Delta Dental. This PPO option is only available if you live outside of Delta's DMO service area or if you have been continuously enrolled in Delta's PPO Dental option since June 30, 2016 with no lapse. If you experience a lapse in coverage, you will automatically be enrolled in the DeltaCare USA DMO if or when your coverage is reinstated.

Regardless of the medical or dental option in which you are enrolled, you are eligible for vision care benefits provided by Anthem Blue Cross, substance abuse benefits, and death and accidental death and dismemberment benefits (for participants only) provided by Plan A. Note, however, that COBRA participants are not covered for death and accidental death and dismemberment

benefits.

Enrollment

Participants are given the opportunity to elect their Plan A options at the time they first become eligible. Election changes are only permitted during an annual open enrollment period designated by the Plan, unless the participant moves his or her primary residence outside their selected plan's service area or their selected HMO/EPO (or Delta Dental DMO) no longer offers coverage in their area. An election change is also permitted on account of a special enrollment opportunity (see page 21). If you plan on moving outside your HMO's or EPO's service area (or Delta Dental's DMO service area), notify the Administrative Office immediately.

Shortly before each annual open enrollment period, the Administrative Office will send you information on the health plan options that may be available to you. You then have a specific period of time to decide if you want to change options and complete and mail your change(s) to the Administrative Office.

If you do not make a new election during an annual open enrollment period, you will retain the same medical and dental coverage elections you had immediately prior to the annual open enrollment period (unless changes are being implemented by the Plan).

WHO MAY BECOME ELIGIBLE

- **Bargaining unit employees** for whom Contributing Employers have made or are required to make contributions to Plan A.

- A person who or whose spouse is a shareholder of a corporation which is a Contributing Employer or who is a member of a limited liability company (LLC) which is a Contributing Employer, is eligible as a bargaining unit employee provided he or she is a member of a local union and the bargaining unit in accordance with the appropriate collective bargaining agreement and with the constitution and bylaws of that local union and the Sheet Metal Workers' International Association.

  Except as may otherwise be agreed to by the collective bargaining parties, and approved by the Plan, the employer must make contributions on behalf of each person described in this item for all hours worked, subject to a minimum of 155 hours per month (130 hours per month for the first six months for newly-organized bargaining units), except the month of hire or termination. In those months, contributions are made on actual hours worked.

  A person who, or whose spouse is a partner or sole proprietor of an unincorporated business which is a Contributing Employer is **not** eligible to participate in Plan A as a bargaining unit employee, but may be eligible to participate in Plan B as a non-bargaining unit employee.

HOW I BECOME ELIGIBLE FOR BENEFITS

Eligibility for benefits is determined by the number of hours worked for Contributing Employers, subject to any minimum requirements. Your Contributing Employer reports, on a monthly basis to the Plan, all hours worked. Hours must be reported by the 20th day of the month immediately

following the month in which the hours were worked. To allow time for processing and reporting information to outside providers and services, the hours are used to determine eligibility for the following month. **Therefore, there is a full month between work month and eligibility month.**

Example: Hours worked in the month of January are due in the Administrative Office no later than February 20 and are used to determine eligibility for the month of March.

For every hour worked, the Contributing Employer must also remit the appropriate monies due, as determined by the collective bargaining agreement. **If your Contributing Employer reports your hours, but fails to remit the required monies due, you will not receive credit for those hours. You will be notified when this occurs, and given the opportunity to gain credit for those hours by submitting a completed "Declaration of Hours Worked" form.**

WHEN MY INITIAL ELIGIBILITY FOR BENEFITS BEGINS

You will initially become covered for benefits on the first day of the second calendar month that follows a period of no more than 2 consecutive calendar months during which period you worked at least 240 hours for Contributing Employers.

Example 1: If you met the 240 hours requirement during the two-month period of January through February, your coverage would begin on April 1.

Example 2: If you worked 240 hours in January, your coverage would begin on March 1.

If an employee is employed by a Contributing Employer on the date the employer signs an initial collective bargaining agreement with a local union participating in the Plan, coverage may begin on the first day of the month after the date the employer signs such agreement. The employee's hour bank (described later) will also be credited with 240 hours on the date coverage commences.

Also, if the business manager of a local union certifies in writing that a new employee, recruited as part of any organizing effort, meets the local union's requirements for a classification for which Plan A benefits are provided, and has begun sheet metal employment with a Contributing Employer within 90 days after he or she left sheet metal employment with a non-Contributing Employer, coverage for the employee will begin on the first day of the month following the date he or she began working for the Contributing Employer. The employee's hour bank will also be credited with 240 hours on the date coverage commences.

IMPORTANT NOTICE: You should retain your payroll check stubs, and contact the Administrative Office if you think your hours have not been properly reported to the Plan.

INITIAL COVERAGE ELECTION

Participants will automatically receive a complete benefit packet from the Administrative Office

when they first become eligible. To ensure coverage and allow time for you to review the options that are available, all participants are automatically enrolled in the Fee-For-Service PPO Medical option for the first month of their eligibility. If you want to enroll in an HMO or EPO medical option, you have 60 days from your initial eligibility date to submit to the Administrative Office a completed enrollment form for the option of your choice. If you do not submit a completed enrollment form within the time allowed, you will remain in the Fee-For-Service PPO Medical option. You will have an opportunity to change your medical option selection during the next annual open enrollment period.

You will also be automatically enrolled in Delta Dental's DMO option if it is determined that you live within Delta's DMO service area, and Delta will assign you and your eligible dependents to its nearest DMO dentist to where you live. You can change your assigned DMO dentist at any time upon 30 days advance notice to Delta Dental. If it is determined that you live outside Delta's DMO service area, you will be automatically enrolled in Delta's PPO dental option.

CONTINUATION OF ELIGIBILITY

Eligibility for benefits is continued on a month-to-month basis, and is determined by the number of hours worked for a Contributing Employer (120 hours worked = 1 month of coverage). All hours worked are credited to your "Hour Bank," up to a maximum equivalent to six months of coverage (before deduction for the current month's coverage). 120 hours is deducted from your Hour Bank on the first day of each month, for that month's coverage. **It is your responsibility to know the status of your Hour Bank, and to know when coverage will terminate**. You may contact the Eligibility Department at the Administrative Office to check on the status of your Hour Bank.

If your eligibility terminates and it is not reinstated as described under "Reinstatement of Eligibility" on page 17, any remaining hours in your Hour Bank will be forfeited. To regain eligibility, you must reestablish eligibility as outlined under "When My Initial Eligibility for Benefits Begins" on page 11.

IMPORTANT NOTICE REGARDING RECIPROCITY AND "TRAVELERS": The Plan is signed to the Master Reciprocal Agreement of the Sheet Metal Workers' International Association, which provides for "money follows the person" reciprocity between related health plans. Under the Master Reciprocal Agreement, when a sheet metal worker "travels" outside the jurisdiction of his or her home local health fund to work in the jurisdiction of a related local health fund, health plan contributions paid on behalf of the traveler are forwarded from the visited local health fund to the traveler's home local health fund, where the sheet metal worker may continue to earn and maintain eligibility and benefits for himself or herself and his or her covered dependents. Please note that "traveling" to work outside the jurisdiction of one's local health plan can raise important logistical and coverage issues for which participants can seek guidance from the Eligibility Department at the Administrative Office.

PENALTIES FOR NON-COVERED SHEET METAL SERVICE

If a participant goes to work or remains at work in Non-Covered Sheet Metal Service, that participant's Hour Bank will be terminated, the participant (and the participant's dependents)

will lose eligibility for coverage, and the participant will not be eligible to make self-payments to the Plan to obtain any coverage including COBRA. If a participant engages in Non-Covered Sheet Metal Service for two calendar quarters the participant will be ineligible to enroll in any retiree health and welfare benefits.

If a participant works in Non-Covered Sheet Metal Service and then returns to employment for an employer required to contribute to the Plan for at least as long a period as the participant had previously worked in Non-Covered Sheet Metal Service, the penalties provided for such work prior to that period may be waived upon the participant's request and approval by the Board of Trustees. A participant may only have one waiver of such penalties in his or her lifetime.

DISABILITY HOURS CREDIT AND CONTINUATION OF ELIGIBILITY DURING DISABILITY

Subject to the requirements below, if you become disabled for a period of at least seven consecutive days, your Hour Bank may be credited with disability hours at the rate of 30 hours for each week you are disabled, beginning with the first day of disability and ending when the maximum disability crediting period has been reached, or when you are no longer disabled, whichever occurs first.

The maximum number of disability hours that can be credited to a bargaining unit employee during a calendar month is 120. Disability hours credit can be given for a maximum of 13 weeks in any twelve consecutive calendar months period.

When you are no longer entitled to disability hours credit, any hours in your Hour Bank will be used to continue your eligibility. If you are still disabled at the time your eligibility ceases, you may be entitled to continue coverage on a self-pay basis. Refer to page 21, "OVERVIEW OF SELF-PAY CONTINUATION OF COVERAGE (PLAN A SELF PAY COVERAGE AND COBRA COVERAGE)."

In order to qualify for disability hours credit, all of the following requirements must be met:

- the disability must be due to injury or illness which prevents you from performing the normal duties of your occupation,
- the disability must be certified by a licensed Physician (M.D.),
- the written certification of disability must be submitted to the Administrative Office no later than 30 days following the date you became disabled, and
- you must have been eligible, other than on a self-pay basis, during the month in which you became disabled.

FAMILY OR MEDICAL LEAVE

The Family and Medical Leave Act of 1993 (FMLA) entitles certain eligible participants to take up to 12 weeks (in some cases, up to 26 weeks), of unpaid, job-protected leave each year for specified family and medical reasons. A Contributing Employer is required to maintain group

health coverage (but not life or disability coverage) for a participant on FMLA leave whenever such coverage was provided to the participant immediately before the leave. To be eligible for FMLA benefits, a participant must:

- work for a Contributing Employer who employs 50 or more employees,
- have worked for that Contributing Employer for at least 12 months,
- have worked at least 1,250 hours for that Contributing Employer over the previous 12 months, and
- work at a location where at least 50 employees are employed by that Contributing Employer within 75 miles.

The service requirements must be met by your work for a single employer. If you worked for more than one employer, you cannot combine your work history under all the employers for whom you worked to meet the service requirements outlined above. For more information on the FMLA, contact your employer.

TRANSFER OF COVERAGE FROM PLAN A TO PLAN B

In the event a participant transfers from Plan A to Plan B, as determined by the collective bargaining agreement, the participant's Hour Bank under Plan A will be used for Plan A coverage until it is exhausted. Coverage will then become effective immediately under Plan B provided the participant has worked at least 110 hours to obtain eligibility and the Administrative Office is timely notified of the participant's change in status.

TRANSFER OF COVERAGE FROM PLAN B TO PLAN A

In the event a participant transfers from Plan B to Plan A, the participant's Hour Bank under Plan B will be used for Plan B coverage until it is exhausted. Coverage will then become effective immediately under Plan A provided the participant has worked at least 120 hours to obtain eligibility and the Administrative Office is timely notified of the participant's change in status.

TERMINATION OF ELIGIBILITY

A participant's coverage will terminate on the earlier of the following dates:

- the last day of the month in which the hours in his or her Hour Bank fall below 120 after deduction of 120 hours for the current month's eligibility;
- the date the participant enters or becomes employed in Non-Covered Sheet Metal Service;
- the date the participant becomes covered by a group insurance plan of an employer of sheet metal workers (while such employer is not contributing to the Plan on his behalf) who has a collective bargaining agreement with a local sheet metal workers' union which participates in the Plan;

- the participant's date of entrance into full-time duty in the Uniformed Services of the United States if such duty continues more than 31 consecutive days unless the participant submits to the Administrative Office within 60 days of entering the Uniformed Services full time, a written election to continue coverage. Refer to "CONTINUED COVERAGE DURING MILITARY LEAVE" below for details on continuing coverage;

- the date Plan A is terminated by the Board of Trustees;

- if a Contributing Employer is delinquent in payment of any contributions due to the Plan or a related plan under a collective bargaining agreement, eligibility for benefits may be terminated or suspended for participants with (or whose spouse has) an ownership or management interest in the employer, and for their dependents, at the Board of Trustees' sole and absolute discretion in accordance with procedures specified in the Trust Agreement. The Board of Trustees also reserves the right to terminate or suspend eligibility of other participants employed by a delinquent employer if the employer remains delinquent, at the Board of Trustees' sole and absolute discretion in accordance with procedures specified in the Trust Agreement.

Upon termination of eligibility, a participant may be entitled to continue coverage on a self-pay basis. Refer to page 21, "OVERVIEW OF SELF-PAY CONTINUATION OF COVERAGE (PLAN A SELF PAY COVERAGE AND COBRA COVERAGE)."

CONTINUED COVERAGE DURING MILITARY LEAVE

The Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA") requires that the Plan provide you with the right to elect continued health coverage for up to 24 months if you are absent from employment due to military service in the Uniformed Services of the United States, including Reserve and National Guard Duty under federal authority, as described below.

Coverage under USERRA

If you are absent from employment because of service in the Uniformed Services, you can elect to continue coverage for yourself and/or your eligible dependents under the provisions of USERRA. The right to elect USERRA coverage does not apply to dependents who enter military service. Further, USERRA rights do not apply to service in a state national guard under authority of state law.

The period of coverage available under USERRA begins on the date on which your absence begins and ends on the earlier of:

- the end of the 24-month period beginning on the date on which the absence begins; or

- the day after the date on which you are required to, but fail to, apply under USERRA for, or return, to a position of employment for which contributions must be made to the Plan.

This right to temporarily continue coverage from the Plan does not include the right to receive any death benefit or accidental death and dismemberment benefits provided under the Plan. In

addition to the right to continued coverage under USERRA, you and your dependents also may have rights to elect continuation coverage under COBRA, if they experience a qualifying event.

Notice and Election of USERRA Coverage

If you want to elect USERRA coverage, you must notify the Administrative Office of your absence from employment due to uniformed service, unless giving notice is precluded by military necessity or unless, under all the relevant circumstances, notice is impossible or unreasonable.

In addition, your election to receive USERRA coverage must be received within 60 days of the last day of covered employment; otherwise, you lose your right to continue your coverage under USERRA.

Paying for USERRA Coverage

You may be required to pay all or a portion of the cost of coverage. If the period of military service is less than 31 days, coverage under the Plan will continue as if you were still working in covered employment. If the military service extends more than 31 days, you must pay 102% of the cost of the coverage. The cost will be determined in the same manner as the cost for COBRA continuation coverage. You should contact the Administrative Office for the current cost.

In accordance with the USERRA rules, hours in an Hour Bank may be applied to cover the cost of continuation coverage during a period of service in the Uniformed Services of the United States. Alternatively, the service member may make self-payments and save the Hour Bank hours to provide coverage after the period of service ends.

USERRA Coverage Requires Timely Monthly Payments

The payment due date is the first day of the month in which USERRA coverage begins. For example, payments for the month of November must be paid on or before November 1st. The payment due for the initial period of USERRA coverage must include payment for the period of time dating back to the date that coverage would have terminated if you had not elected USERRA coverage. There is an initial grace period of 45 days to pay the first premium due, starting with the date USERRA coverage was elected. After that, there is a grace period of 30 days to pay any subsequent amounts due.

If you timely elect and pay for USERRA coverage, coverage will be provided retroactive to the date of your departure for military service. If payment is not received by the end of the applicable grace period, USERRA coverage will terminate as of the end of the last period for which payment was received.

If you fail to pay the full payment by each due date (or within the 30-day grace period), you will lose all USERRA coverage and such continuation coverage cannot be reinstated.

Once a timely election of USERRA coverage is made, it is your responsibility to make timely payments. The Administrative Office will not send notice that a payment is due or that it is late, or that USERRA coverage is about to be terminated due to the untimely payment of a required

payment.

When you return to covered employment after receiving an honorable discharge within the time periods required by law, you will be eligible to continue your coverage from the Plan. However, if there is an insufficient balance remaining in your Hour Bank account to continue your coverage at that time, you must self-pay your premiums in order to continue your coverage.

REINSTATEMENT OF ELIGIBILITY

Your eligibility will be reinstated on the first day of the second calendar month after your Hour Bank again reflects at least 120 hours if the 120 hours were accumulated within the six calendar months immediately following the date your eligibility terminated because of insufficient work hours.

If you are continuing your coverage on a self-pay basis, your eligibility will be reinstated on the first day of the second calendar month after your Hour Bank again reflects at least 120 hours if the 120 hours were accumulated in the six calendar month period immediately following termination of self-pay eligibility.

Coverage will also be reinstated for employees who are honorably discharged from full-time duty in the Uniformed Services of the United States on the first day the employee returns to, or is available for, active employment with a Contributing Employer if he or she returns to work or is available for work on whichever of the following dates is applicable:

- within 14 days of completing military service for a leave of 31 to 180 days,

- within 90 days of completing military service for a leave of more than 180 days.

When coverage is reinstated, all provisions, limitations and exclusions of Plan A will apply to the extent that they would have applied if the employee had not taken military leave and his or her coverage had been continuous under Plan A.

RESCISSION OF COVERAGE

In accordance with the Affordable Care Act, the Plan will not retroactively cancel coverage (a rescission) except when contributions and self-payments are not timely paid, or in cases when an individual performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact that is prohibited by the terms of Plan A.

WORK AFTER RETIREMENT

At age 65 (or at age 55 if a retiree is working in pre-approved employment under the "55/25 Rule") a retired participant may work in the Sheet Metal Industry under rules set forth in the plan booklet for the Sheet Metal Workers' Pension Plan of Southern California, Arizona and Nevada ("Pension Plan") and continue to receive pension benefits from the Pension Plan. Such work will not be credited to the retired participant's Hour Bank for health coverage eligibility, and the retired participant will not be eligible for health coverage under Plan A or Plan B by virtue of such employment. At April 1 of the year following the year a retired participant reaches age 70-

1/2, the participant's work in the Sheet Metal Industry is unrestricted, and the retiree may establish Plan A or Plan B coverage by virtue of such employment, unless it is work under the 55/25 Rule.

DEPENDENT ELIGIBILITY

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

Eligible Dependents

Eligible dependents include the participant's:

- legal spouse (former spouses are <u>not</u> eligible after the effective date of the dissolution of marriage or final divorce decree);
- unmarried or married children through the last day of the month in which the child turns age 26 (through age 18 for death benefits);
- unmarried dependent child 26 years of age or older if the child is **solely** dependent upon the participant for support and is totally prevented from earning a living because of a mental or physical disability. The disabled child must have been disabled while covered under Plan A or Plan B prior to reaching the limiting age of 26. Alternatively, within the five-year period preceding the time the participant began accruing an hour bank leading to the participant's coverage through the Plan, the child must have been disabled while covered under a related multi-employer health plan covering sheet metal workers employed under a collective bargaining agreement with a Sheet Metal Workers International Association local union, prior to reaching the limiting age of 26.

  The disability must be certified by a Physician and such certification must be submitted to the Administrative Office annually.

  Children include the participant's natural child, legally-adopted child, child "placed for adoption" if under 18 years old, or any other child for whom, by a Qualified Medical Child Support Order (QMCSO) as described on page 20, or court order of legal guardianship, the participant is legally responsible for the child's health care expenses. Refer to the "Glossary" section for a description of a QMCSO. A child is "placed for adoption" (as stated above) with you on the date you first became legally obligated to provide full or partial support of the child whom you plan to adopt. If the participant is the legal guardian of a child who is not a "relative," as listed in Internal Revenue Code Section 152(d)(2)(A) through (G), the child must, for the entire year, have the same principal place of abode as the participant and be a member of the participant's household.

A spouse or child who is eligible as a participant under any of the Plan options provided through the Sheet Metal Workers' Health Plan of Southern California, Arizona and Nevada, will also be

eligible as a dependent. A dependent child of two eligible participants will be covered as a dependent of each participant. When dual coverage exists as described in this paragraph, benefits are typically coordinated. The coordination of benefits provisions under Plan A's Fee-For-Service PPO Medical option are described on page 67. The HMOs/EPO have their own coordination of benefits rules, which are described in their Evidence of Coverage booklets.

Adding New Dependents

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

IMPORTANT NOTICE REGARDING CHANGES IN DEPENDENT STATUS

You must IMMEDIATELY notify the Administrative Office in writing whenever a dependent status change occurs, except for an automatic change based on the age of a dependent child. This includes final dissolution of marriage or death. The changing of a participant's beneficiary for death benefits is not acceptable notification of divorce.

If you do not immediately notify the Administrative Office in writing, and claims or premiums are paid on behalf of an ineligible dependent, the participant and dependent are responsible for reimbursing the Plan for such claims or premiums, or both, including attorney's fees, interest, and reasonable collection costs. The Plan may recover these amounts through legal action or otherwise as determined in the sole and absolute discretion of the Board of Trustees or a duly authorized committee of the Board of Trustees. The participant and dependent may also be required to reimburse the Plan and/or HMO for the value of any HMO benefits provided to the ineligible dependent.

Date Coverage Begins for Dependents

Coverage for a participant's eligible spouse and eligible dependent children begins on the date the participant's coverage begins or the date the participant acquires the dependent, whichever is later, subject to proper and timely enrollment. A child who is placed for adoption with you within 31 days after the child was born, will be covered from birth if you comply with the requirements for adding newly acquired dependents.

If the Administrative Office does not receive the necessary enrollment form and any required documentation for newly acquired dependents within 31 days following the date dependency status is met, the coverage effective date for such dependents will be delayed until the first day of the month following the date the Administrative Office receives the forms and documentation.

Termination of Eligibility for Dependents

A dependent's coverage will terminate on whichever of the following dates occurs first:

- the date the participant's eligibility terminates;
- the last day of the month in which the dependent no longer meets the qualifications of a dependent;
- the date of entrance into full-time military service;
- the date coverage for dependents is terminated by the Board of Trustees;
- the date the dependent enters or becomes employed in Non-Covered Sheet Metal Service.

A dependent cannot be voluntarily dis-enrolled from Plan A. That is, unless an event occurs that would result in a dependent's termination of coverage as described above, a dependent's coverage will continue under Plan A.

If a participant dies while still covered under Plan A's Hour Bank provision, eligible dependents of that participant will remain covered until the hours in the deceased participant's Hour Bank fall below 120; however, such coverage will terminate immediately upon the remarriage of the surviving spouse.

Upon termination of eligibility, a dependent may be entitled to continue coverage on a self-pay basis. Refer to page 26, "COBRA COVERAGE."

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

If a court or state administrative agency has issued an order (including approval of a settlement agreement) or National Medical Support Notice with respect to health care coverage for any dependent child of an employee, a copy of the order should be promptly mailed to the Administrative Office. The Plan will determine if the order is a Qualified Medical Child Support Order (QMCSO) in accordance with federal law. That determination will be binding on the employee, the other parent, the child, and any other party acting on behalf of the child. The Plan will notify the parents and each child if an order is determined to be a QMCSO and if the employee has coverage under the Plan, and advise them of the procedures to be followed to provide coverage of the dependent child(ren).

If the employee is a Plan participant, the QMCSO may require the Plan to provide coverage for the employee's dependent child(ren) and to accept any required contributions for that coverage from a parent who is not a Plan participant. The Plan will accept a special enrollment of the dependent child(ren) specified by the QMCSO from either the employee or the custodial parent. Coverage of the dependent child(ren) will become effective on the 1st day of the month following the date the order is received by the Plan, and will be subject to all terms and provisions of the Plan.

If the employee is not an eligible Plan participant at the time the QMCSO is received, the Plan will return the documents to the sender and notify all interested parties that coverage under the Plan is not available to the dependent child until such time the employee becomes covered under the Plan.

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

SPECIAL ENROLLMENT

If you decide not to enroll your dependents because they have other health coverage, you may be eligible to request immediate or retroactive enrollment for your dependents in Plan A coverage if your dependents lose other health coverage. You must notify the Administrative Office and submit an enrollment application within 31 days after the other coverage ends. However, if you or your dependents lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage or become eligible for a state subsidy for enrollment in the Plan under Medicaid or CHIP, you must properly enroll your dependents in Plan A coverage within 60 days after coverage in Medicaid/CHIP ends or the date they became eligible for the subsidy. If you properly enroll your dependents within these periods, coverage will be retroactive to the date prior coverage ended.

In addition, if you acquire a new dependent as a result of marriage, birth, adoption, or placement of a child with you for adoption, you can request enrollment for your new dependent retroactive to the date the dependent attained dependent status as long as you notify the Administrative Office in writing within 31 days of the marriage, birth, adoption, or placement for adoption.

If you enroll your dependents under the terms described in this Special Enrollment provision, you will be given the opportunity at the time dependent enrollment occurs to change your medical benefit option to any other option available under Plan A to similarly situated participants in your geographical area. Please note, however, that your dependents may only be enrolled under the medical benefit option that covers you. In other words, you can't be covered by one option and your dependents covered by a different option.

OVERVIEW OF SELF-PAY CONTINUATION OF COVERAGE (PLAN A SELF PAY COVERAGE AND COBRA COVERAGE)

A participant whose eligibility will terminate due to insufficient work hours or a disability may continue coverage for himself and his eligible dependents on a self-pay basis. **If you are not retiring,** you may have the choice between the following two self-pay options – COBRA coverage under Plan A, or the Plan's self-pay Plan A coverage for unemployed or disabled participants. Both coverage options require monthly self-payments and are provided for a limited period (as explained later). Upon expiration of either coverage, you are **not** entitled to the other coverage. That is, if you enroll in the Plan A's self-pay coverage for unemployed or disabled participants, upon termination of that coverage you cannot enroll in COBRA coverage and vice versa. You also cannot switch between these two coverages at any time during the period of coverage; once you have elected one coverage, you may no longer choose the other.

Retiring sheet metal workers or surviving family members who qualify for enrollment in the Plan's retiree health plan may either elect to extend active health benefits under COBRA coverage or enroll in the retiree health plan. If Plan A COBRA coverage is chosen, you may enroll in the Plan's retiree health plan after Plan A COBRA coverage terminates. **However,**

your retiree self-pay contribution may be significantly higher than it would be if you had rejected Plan A COBRA coverage and enrolled in the retiree health plan when you were first eligible to do so. For information on the retiree self-pay contribution rates contact the Administrative Office.

COBRA coverage is also separately available to dependents or former dependents as explained in the COBRA section.

Please note that a lapse of eligibility for health coverage lasting 3 consecutive months may cause you to owe an individual shared responsibility payment pursuant to the Affordable Care Act. The individual shared responsibility payment is due when you file your individual tax return.

You may avoid having to pay the individual shared responsibility payment by becoming covered under another health plan that qualifies as minimum essential coverage. Examples of minimum essential coverage include Plan A's self-pay coverage for unemployed or disabled participants, Plan A's COBRA coverage, or a plan available through the Affordable Care Act Marketplace or Exchange in your area.

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

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

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

PLAN A SELF-PAY COVERAGE FOR UNEMPLOYED OR DISABLED PARTICIPANTS

Who Is Eligible

A participant whose eligibility will terminate because his or her hours will fall below 120 is eligible to enroll the participant and the participant's eligible dependents in this self-pay coverage if the following conditions are met:

- for a non-disabled participant, the participant is on the out of work list and available for covered employment as evidenced by the records of the participant's local union, or

- for a disabled participant, the participant is unable to work as a sheet metal worker because of his or her disability as determined in the sole and absolute discretion of the Plan, and

- neither the participant nor his or her spouse is employed in Non-Covered Sheet Metal Service.

You are NOT eligible for this self-pay coverage if your eligibility is lost because of delinquent

owner-operator status (see page 15).

Enrollment and Self-Payment

The unemployed or disabled participant must apply for this self-pay coverage and submit monthly self-payments to the Administrative Office. The application form and information on the self-pay rates is available from the Administrative Office.

You must submit the completed application form and the required first month's self-payment (by check or money order) to the Administrative Office by the 10th day of the month **before** your Active eligibility is scheduled to terminate. Applications and/or self-payments received by the Administrative Office after this deadline will not be accepted.

After receipt of a timely submitted and properly completed application form and initial self-payment, the Plan will determine if you qualify for this self-pay coverage. You will be notified in writing of the Plan's determination. If it is found that you do not qualify for this self-pay coverage your check or money order will be returned to you. In such a case, you may still be able to extend your coverage if you qualify for and properly enroll in COBRA coverage as explained on page 26.

If your enrollment in this self-pay coverage is approved by the Plan, subsequent monthly self-payments are due by the 20th day of the month before each consecutive coverage month. Failure to make the required self-payment by the due date will result in automatic termination of coverage. Once self-pay coverage is terminated it cannot be reinstated. **The Administrative Office does not send monthly bills or warning notices. It is your responsibility to submit self-payments when due.**

Please be aware that the monthly self-pay rates for this coverage are not guaranteed for any specific time period and they may be changed from time to time at the sole and absolute discretion of the Board of Trustees. Self-pay participants will be notified in advance of any changes to the self-pay rates.

Type of Coverage

The coverage provided under this self-pay extension consists of all Plan A coverage, including medical, prescription drug, dental, vision, and death benefits and accidental death and dismemberment benefits.

Self-Pay Coverage for Your Dependents

In order for your existing eligible dependents to be covered under this self-pay extension, you must elect coverage for them by listing them on the application form and submitting the applicable self-pay rate for two party (participant plus one dependent) or family (participant plus two or more dependents) coverage as described above under Enrollment and Self-Payment. Otherwise, your dependents will not be covered by the Plan and cannot be added at a later date under this self-pay extension unless a special enrollment event occurs as described under Special

Enrollment on page 21.

A participant may, in writing, elect to "suspend" self-pay coverage of dependents who were covered previously under Actives coverage, if doing so would result in a lower monthly self-pay premium. The participant may make such an election ONLY when he or she first enrolls on the self-pay plan OR when a qualifying event occurs (in which case proof is required). Qualifying events include when other group health plan coverage or Medicare coverage is acquired by the dependent.

"Suspended" dependents will remain "suspended" until the participant's Active coverage is reinstated. At that time, all otherwise-eligible "suspended" dependents will automatically be reinstated to coverage as eligible dependents. Reactivation of suspended dependents' self-pay coverage can occur sooner, if the dependent experiences a qualifying event (in which case proof is required). Qualifying events include loss of other group health plan coverage (including Medicaid or CHIP) or Medicare coverage by the dependent (see Special Enrollment on page XX). Doing so may change the amount you must pay for self-pay coverage

Adding New Dependents

Self-pay participants may add newly acquired dependents to their self-pay coverage. Refer to page 19 under Adding New Dependents and Date Coverage Begins for information. Adding a new dependent may change the amount you must pay for self-pay coverage.

Maximum Continuation Period

The maximum self-pay continuation period depends on whether or not you have been previously covered under this self-pay extension. And, it may be cut short as explained below under "Termination of Coverage."

The maximum coverage period applies to both unemployed and disabled self-pay participants. Subject to the provisions in the next paragraph, the initial maximum coverage period is 6 consecutive months. A self-pay participant can apply to the Plan for an additional 6 consecutive months of coverage. **In no event, however, will self-pay coverage be provided for more than 12 consecutive months with one exception as follows.**

Exception: If a disabled participant has applied for a disability pension from the Sheet Metal Workers' Pension Plan of Southern California, Arizona and Nevada, and such pension is pending a determination of disability from the Social Security Administration, the participant may apply to the Plan for a single additional extension of 6 consecutive months (for a maximum self-pay coverage period of 18 months).

The maximum coverage period may be reduced by prior use of the self-pay coverage. A participant who was previously enrolled in self-pay coverage will be eligible for a maximum of 6 months plus an additional 6 months (if approved), less the number of months of self-pay coverage previously used. However, if a self-pay participant goes back to work for a contributing employer and has one or more months of active coverage, the reduction to the self-pay maximum coverage period for prior use will be reduced for each month the participant has active coverage.

For Example: A participant uses 6 months of self-pay coverage, then goes back to work and has active coverage for 3 months. He then reapplies for self-pay coverage. This participant would have a maximum of 9 months of available self-pay coverage: 12 month limit – 6 months previously used + 3 months of active coverage = 9 available months. This example assumes the participant's application for an additional 6-month extension is approved. If it were not approved, the participant would have a maximum of 3 months of available self-pay coverage: 6 month limit – 6 months previously used + 3 months of active coverage = 3 available months.

Termination of Coverage

Self-pay coverage will terminate before the maximum continuation period has expired if any of the following events occur:

- the participant retires, in which case coverage will terminate as of the date of retirement;
- the required self-payment is not submitted by the due date, in which case coverage will terminate at the end of the month for which payment was received;
- the participant's date of entrance into full-time duty in the Uniformed Services of the United States if such duty continues more than 31 consecutive days unless the participant submits to the Administrative Office within 60 days of entering the Uniformed Services full time, a written election to continue coverage. Refer to "CONTINUED COVERAGE DURING MILITARY LEAVE" on page 15.
- the non-disabled participant is not available for covered employment in which case coverage will terminate on the date the participant becomes unavailable for covered employment;
- the participant becomes covered by a group insurance plan of an employer of sheet metal workers (while such employer is not contributing to the Plan on his behalf) who has a collective bargaining agreement with a local Sheet Metal Workers' Union which participates in the Plan, in which case coverage will terminate on the date coverage under such group insurance plan becomes effective;
- termination of this self-pay provision by the Board of Trustees, in which case coverage will terminate on the date established by the Board of Trustees;
- modification of this self-pay provision by the Board of Trustees when such modification limits or excludes coverage for a class of individuals to which you belong, in which case coverage will terminate on the date established by the Board of Trustees;
- the participant (or covered dependent) works in Non-Covered Sheet Metal Service, in which case coverage will terminate on the date of such employment.

Once self-pay coverage is terminated it cannot be reinstated. And, upon termination of this self-pay coverage, you will **not** be entitled to the COBRA coverage described below.

COBRA COVERAGE

Who Is Eligible

A participant or dependent covered under Plan A is entitled to enroll in COBRA coverage if eligibility under the Plan is lost because of one of the following qualifying events:

For Participants

If you are a participant, COBRA continuation coverage is available to you if coverage would otherwise end because either one of the following qualifying events happens:

1. Your hours of covered work are reduced so that you are no longer eligible to participate in the Plan, or
2. Your employment ends for any reason other than gross misconduct.

For a Spouse

If you are the spouse of a participant, COBRA continuation coverage is available to you if coverage would otherwise end because any one of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than gross misconduct; or
4. You become divorced from your spouse.

For Dependent Children

COBRA continuation coverage is available to your dependent children if coverage would otherwise end because any one of the following qualifying events happens:

1. The parent-participant dies;
2. The parent-participant's hours of employment are reduced;
3. The parent-participant's employment ends for any reason other than gross misconduct;
4. The parents become divorced; or
5. The child no longer meets the requirements of an eligible dependent.

You are NOT eligible for COBRA coverage if you are working in Non-Covered Sheet Metal Service or if your eligibility is lost because of delinquent owner-operator status. COBRA coverage will automatically terminate as of the date you start work in Non-Covered Sheet Metal Service. Once terminated, COBRA coverage cannot be reinstated. You are also NOT eligible for COBRA coverage if you were covered under the Plan A's self-pay coverage described previously.

Retiring sheet metal workers or surviving family members who qualify for enrollment in the Plan's retiree health plan may elect to either extend active health benefits under COBRA coverage or enroll in the retiree health plan. If Plan A COBRA coverage is chosen, you may enroll in the Plan's retiree health plan after Plan A COBRA coverage terminates. **However, your monthly retiree self-pay contribution may be significantly higher than it would be if**

you rejected Plan A COBRA coverage and enrolled in the retiree health plan when you were first eligible to do so. For information on the self-pay contribution rates contact the Administrative Office.

Notification Requirements

COBRA continuation coverage will be offered to qualified beneficiaries only after the Administrative Office has been notified that a qualifying event has occurred. When the qualifying event is divorce of the participant and spouse or a dependent child's losing eligibility for coverage, the participant or dependent is responsible for giving notice to the Administrative Office as soon as possible but not later than 60 days after the date of the qualifying event or the date coverage under Plan A is lost as a result of the event.

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

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

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

A family member should also contact the Administrative Office in the event of the death of the participant. It is not necessary for a participant or dependent to notify the Administrative Office in the event eligibility is lost because of termination of employment or insufficient work hours.

After the participant and/or dependent(s) are notified of their right to elect COBRA coverage, the Administrative Office must be advised, by submission of a completed COBRA enrollment form, of the desire to continue coverage within 60 days after the later of 1) the date Plan A coverage would be lost, or 2) the date the participant and/or dependent(s) were notified of the right to elect COBRA coverage.

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

If the participant elects not to continue coverage, his or her dependent(s) may independently elect such coverage.

Type of Coverage

COBRA coverage consists of Plan A medical, prescription drug, dental, and vision care benefits. Death benefits, and accidental death and dismemberment benefits, are not provided to an individual enrolled in COBRA coverage.

COBRA participants may change their coverage selections on the same basis as active participants as described on page 10 under *"Enrollment"*.

Cost of and Payment for COBRA Coverage

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

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

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

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

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

Continuation Period for COBRA Coverage

For each qualified participant or beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date coverage under Plan A would otherwise have ended.

COBRA continuation coverage is a temporary continuation of coverage, as follows:

- When the qualifying event is the death of the participant, his or her divorce, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to

36 months.

- When the qualifying event is the end of employment or reduction of the participant's hours of employment, COBRA continuation coverage lasts for up to 18 months. However, this 18-month period of COBRA continuation coverage can be extended three ways, as described below.

  - The 18-month continuation period may be extended an additional 11 months (29 months in total) if Social Security determines that the participant or dependent was totally disabled when Plan A coverage would have terminated or within 60 days of that date. In order to qualify for the disability extension, the Social Security disability determination must be reported and a copy sent to the Administrative Office before the initial 18 months of COBRA coverage expires and within 60 days after the date of the Social Security determination. The extension is available to the disabled person and his or her eligible family members enrolled in COBRA coverage.

  - If a participant becomes entitled to Medicare prior to experiencing qualifying event 1, as described on page 31, his or her dependents may continue coverage for the longer of a) 18 months from the date coverage would have otherwise terminated, or b) 36 months from the date of the participant's Medicare entitlement.

  - The 18-month period of COBRA coverage may be extended to 36 months for second qualifying events that occur within the initial 18-month period of coverage. This extension is only available to individuals who were dependents at the time of the initial qualifying event and to children who were born to or adopted by the participant during the 18-month period of COBRA coverage. **You must make sure that the Administrative Office is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be in writing and mailed to the Administrative Office at the address shown on page 27.**

Maximum Duration of COBRA Continuation Coverage for Different Qualifying Events		
Qualifying Event	**Who May Continue Coverage**	**Maximum Period of Continuation Coverage (measured from the date eligibility would otherwise terminate)**
You (the participant) lose eligibility due to • a reduction in your hours of covered work, or • qualifying termination of your hours of covered work, including retirement	You, your spouse, and/or your Dependent children covered under the Plan	18 months*
You die	Your spouse and/or your Dependent children covered under the Plan	36 months

You and your spouse divorce	Your former spouse and/or your Dependent children covered under the Plan	36 months
Your child ceases to meet the Plan's definition of an eligible Dependent (for example, because of a change in age)	The Dependent child who was covered under the Plan	36 months
** Coverage may be continued an additional 11 months (for a total of 29 months) if you or a covered Dependent becomes disabled as determined by the Social Security Administration before or during the first 60 days of COBRA continuation coverage. If you were already enrolled in Medicare (Part A or Part B) when your hours of covered work were reduced or terminated, your Dependents may continue COBRA coverage for 18 months (29 in the case of a disability extension) from the date they would have lost coverage because of that qualifying event or 36 months from the date you became enrolled in Medicare, whichever ends later.*		

Termination of COBRA Coverage

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

- termination of the Plan;
- failure of a participant or dependent to pay the required premium in full and on a timely basis;
- a participant or dependent becomes covered, after his or her COBRA election date, under another group health plan;
- a participant or dependent becomes entitled to Medicare after his or her COBRA election date;
- in the case of a totally disabled individual extending COBRA coverage an additional 11 months, Social Security determines that the disability no longer exists. If this occurs, COBRA coverage will terminate for the individual and his or her eligible dependents starting with the month that begins 30 days after the date that Social Security determines that the qualified beneficiary is no longer disabled;
- a participant or dependent works in Non-Covered Sheet Metal Service.

Newly Acquired Dependents

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

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

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

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

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

Other Events

If, while a participant is enrolled in COBRA continuation coverage under Plan A, his or her eligible dependent who is not enrolled in COBRA coverage under Plan A loses coverage through Medicaid or a State children's health insurance program (CHIP) or becomes eligible for a premium assistance program through Medicaid or CHIP, the participant may enroll the eligible dependent for COBRA coverage under Plan A for the balance of the period of COBRA continuation coverage. The spouse or dependent must have been eligible for COBRA coverage as of the date of the initial Qualifying Event, but have not enrolled.

The participant must enroll the spouse or dependent *within 60 days* after the date Medicaid or CHIP coverage is lost or the date the spouse or dependent is determined to be eligible for premium assistance.

California COBRA Law (Cal-COBRA) – Applicable Only to HMO Participants in California

If you are a COBRA participant enrolled in a California HMO, a California law known as "Cal-COBRA" may allow you to extend the length of continuation coverage. This law applies only to your HMO medical coverage.

If your qualifying event was a reduction in or termination of your hours of covered work and you exhaust the 18 months of COBRA continuation coverage normally available after such a qualifying event (or the 29 months available in the case of disability), under Cal-COBRA you may be able to continue your HMO medical coverage (under the same HMO plan) for an additional 18 months (or an additional 7 months in the case of a disability).

For more information about your rights under Cal-COBRA, contact your HMO.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Administrative Office informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Administrative Office.

If You Have Questions

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

Conversion to Individual Coverage (applicable only to HMO/EPO participants)

Under certain circumstances, participants and eligible family members whose coverage through an HMO/EPO ends, may be allowed to purchase individual conversion coverage through their HMO/EPO without evidence of insurability. Individuals must apply for conversion coverage and pay the premium within 31 days of the loss of their coverage.

To take advantage of this provision, your individual coverage must be through the same HMO/EPO plan. For more information, contact your HMO/EPO.

CHAPTER 2 - FEE-FOR-SERVICE PPO MEDICAL OPTION

The provisions and benefit descriptions in this Chapter apply to participants and eligible dependents enrolled in the Fee-For-Service PPO Medical option under Plan A. If you are enrolled in an HMO or EPO, you should refer to the benefit booklet (Evidence of Coverage) issued by the HMO or EPO for your medical and prescription drug coverage.

In this Chapter you'll find information on:

- **Utilization Review Program**
- **Special provisions regarding women's health care**
- **PPO Program**
- **Medical deductible**
- **Out-of-Pocket maximum**
- **Benefits for covered services**
- **Limitations and exclusions**
- **Nondiscrimination in health care**
- **Claims filing procedures**

UTILIZATION REVIEW PROGRAM FOR PARTICIPANTS COVERED UNDER THE FEE-FOR-SERVICE PPO MEDICAL OPTION

The Utilization Review Program provides the necessary professional assistance to help patients receive the best possible medical care while monitoring the costs of care. There are three utilization review programs, one designed specifically for substance abuse rehabilitation treatment, which is administered by Beat It, one designed specifically for transplants, which is administered by Anthem Blue Cross, and one for all other health care (including inpatient admission for substance abuse detoxification) which is also administered by Anthem Blue Cross.

The utilization review program for substance abuse rehabilitation treatment is voluntary. Before seeking any rehabilitation treatment for substance abuse, you or someone on your behalf are urged to call Beat It toll free at (800) 828-3939. The care counselors at Beat It will assist in finding the patient the needed level of care, and will negotiate special provider discounts that could save you out-of-pocket costs. Please note that inpatient admission for detoxification should be authorized by Anthem Blue Cross.

The utilization review program for transplants is mandatory. You must have your treatment pre-authorized and managed by Anthem Blue Cross in order to receive any benefits from the Fee-For-Service PPO Medical option. Before seeking a pre-transplant evaluation, you or someone on your behalf must call Anthem Blue Cross toll free at (800) 274-7767, or in Nevada (800) 336-7767, in order to receive benefits for Allowable Charges.

The utilization review program for other care is voluntary. Although the utilization review program is not mandatory for other care, you or someone on your behalf are urged to call Anthem Blue Cross toll free (800) 274-7767, or in Nevada (800) 336-7767, if your Physician recommends or prescribes any of the items listed below. The call should be made at least 72 hours prior to receiving care. In the case of emergencies, the call should be made within 48

hours following treatment.

- Hospitalization, including inpatient substance abuse detoxification (for substance abuse rehabilitation treatment call Beat It rather than Anthem Blue Cross). If hospitalization is for childbirth, it is not necessary to call for pre-authorization if your Physician is prescribing a length of stay of 48 hours or less for a normal vaginal delivery or 96 hours or less for a cesarean section.
- Surgery
- Second or third opinions on the need for a proposed surgery (if pre-authorization is obtained, benefits for Allowable Charges for the second or third opinion are payable at 100% rather than at regular benefit levels)
- pain management such as epidural injections
- nursing care
- durable medical equipment
- home infusion therapy
- home health care
- treatment of TMJ dysfunction
- vision therapy
- hormone therapy
- physical therapy
- speech therapy
- sleep therapy

Regardless of whether or not you obtain pre-authorization for a proposed treatment program, all services are subject to retrospective review by an independent medical consultant to determine if they are Covered Services.

With this single phone call, important cost containment "checks" are put into effect to help you and the Plan avoid unnecessary or unexpected costs. After you make the initial call, Anthem Blue Cross will do the rest of the work for you. This means consulting with your Physician, making arrangements for home health care, if necessary, and keeping you informed when decisions have to be made.

Here is how the program works:

Step 1

Your Physician discusses with you plans for non-Emergency surgery, hospitalization, or other treatment.

Step 2

You or your Physician's office calls Anthem Blue Cross at (800) 274-7767, or in Nevada (800) 336-7767, for pre-authorization before non-Emergency treatment is rendered. For non-Emergency hospitalization or surgery, the call should be made at least 72 hours before the scheduled admission or surgery. For a transplant, the call **must** be made before you undergo a pre-transplant evaluation. If the treatment is in connection with substance abuse, all rehabilitative care (not detoxification services) should be arranged through Beat It at (800) 828-

3939.

Note: In most cases, when you use a PPO provider, that provider will handle the pre-authorization request for you.

Step 3

You or your provider will be asked basic information such as your name and the participant's Social Security number, your Physician's name and phone number and, for hospitalizations, the Hospital where you will be admitted.

Step 4

Health professionals contact your Physician to obtain pertinent information about your medical history and current condition.

Step 5

Based on the information obtained from your Physician and utilization review guidelines, a determination is made on your proposed care. When your hospitalization is pre-authorized, it is for a specific number of days in the Hospital. You will receive written verification of this as will the Hospital and Physician. Your pre-authorized stay has been agreed to by your Physician.

Step 6

If you are hospitalized, the utilization review professionals will stay in contact with the Hospital throughout your stay to be sure you are progressing and that your stay is developing as planned. Should complications develop and you are not being discharged as planned, you or a family member or your Physician must call Anthem Blue Cross at (800) 274-7767, or in Nevada (800) 336-7767, so that the necessary information can be obtained to support your extended stay.

Remember

- Pre-authorization is based on your personal medical history, not national statistics.
- If your care is not authorized for any reason, you or your Physician may discuss your case with the Utilization Review Firm's medical consultants.

Case Management (administered by Anthem Blue Cross)

Case management goes one step beyond the pre-authorization process for cases which represent catastrophic health care such as transplants, multiple traumas, head injuries, certain forms of cancer, burns, congenital abnormalities, or pain management. These catastrophic cases benefit from close management due to their length, severity, and complexity. Case Management helps to avoid devastation of personal and group benefit dollars.

This part of the Utilization Review Program allows you to be reasonably sure that the patient is receiving appropriate care for his or her level of illness or injury while containing costs.

Case Management is a service available to participants and their families when specific medical criteria are met. Not everyone who is hospitalized will need this service.

Restrictions and Limitations of the Utilization Management Program (Important Information):

- The fact that your health care provider recommends surgery, hospitalization, confinement in a health care facility, or that your health care provider proposes or provides any other medical services or supplies, doesn't mean that the recommended services or supplies will be an eligible expense or be considered Medically Necessary for determining coverage.

- The Utilization Management Program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. Anthem's certification that a service is Medically Necessary doesn't mean that a benefit payment is guaranteed. Eligibility for and actual payment of benefits are subject to the terms and conditions of Plan A as described in this document. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered or if the services were not covered by the Fee-For-Service PPO Medical option either in whole or in part.

- All treatment decisions rest with you and your health care provider. You should follow whatever course of treatment you and your health care provider believe to be the most appropriate, even if Anthem does not certify proposed surgery/treatment/service or admission as Medically Necessary or as an eligible expense. However, the benefits payable may be affected by the determination of Anthem.

- With respect to the administration of this utilization review program, the Plan, the Board of Trustees, the Administrative Office, and Anthem are <u>not</u> engaged in the practice of medicine, and none of them take responsibility either for the quality of health care services actually provided, even if the services have been certified by Anthem as Medically Necessary, or for the results if the patient chooses not to receive health care services that have not been certified by Anthem as Medically Necessary.

- Precertification of a service does not guarantee that benefits for that service will be paid because other factors, such as ineligibility for coverage on the actual date of service, the information submitted during precertification varies from the actual services performed on the date of service, and/or the service performed is not a covered benefit, may be a factor in non-payment of a service.

SPECIAL PROVISIONS REGARDING WOMEN'S HEALTH CARE

Federal law guarantees certain rights to women.

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean

section. However, the plan or issuer may pay for a shorter stay if the attending provider (for example, your Physician), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

Under the Women's Health and Cancer Rights Act of 1998, all plans that cover mastectomies are also required to cover related reconstructive surgery. Available reconstructive surgery must include both reconstruction of the breast on which surgery was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance. Coverage must also be available for breast prostheses and for the physical complications of mastectomy, including lymphedema. These services are elective and are chosen by the patient in consultation with the attending Physician. They are subject to the usual deductible, co-insurance, and co-payment provisions.

PREFERRED PROVIDER (PPO) PROGRAM

The Plan has agreements with preferred provider organizations (PPOs). The primary purpose of a PPO is to contract with Hospitals, Physicians, and other health care professionals to provide you with medical care at lower prices. Providers must meet certain criteria established by the PPO such as holding a proper license or certification, in order to be accepted into the PPO network. The PPO will help you and the Plan save money.

The Plan contracts with Anthem Blue Cross to provide a PPO network in California and Nevada.

How the Program Works

Remember that all services and supplies in connection with organ transplants require pre-authorization. Refer to page 33 for details.

- When you need to see a Physician or other health care provider, simply select one from the Anthem Blue Cross PPO provider network. You can locate PPO providers by visiting the Plan's website at **www.sheetmetalsam.org** and clicking on the applicable link for Anthem Blue Cross California or Nevada. Because the provider networks change from time to time, when you call the provider's office for an appointment you should verify that the provider is still participating in the Anthem Blue Cross Prudent Buyer Network.

- When you obtain care from a PPO Provider, you simply present your Sheet Metal Workers' Health Plan ID card to the admitting/billing clerk. That's all there is to it; there is no special paperwork and the provider will submit the claim forms for processing.

- **If services of a specialist are required, request a referral to a PPO Provider Specialist. If you go to a PPO Provider Physician and you get referred to another Physician, be**

sure that the other Physician is a PPO Provider Physician.

- **If elective hospitalization or surgery is recommended by your Physician, request that you be referred to a PPO Provider Hospital or PPO Provider Ambulatory Center and call toll free (800) 274-7767, or in Nevada (800) 336-7767, for pre-authorization of the proposed admission or procedure. Not all PPO Physicians automatically refer patients to PPO facilities so it is very important that you advise your Physician that you want to be referred to a PPO facility.**

- **If you need durable medical equipment or home infusion or respiratory services, call toll free (800) 274-7767, or in Nevada (800) 336-7767, for referral to a PPO Provider.**

- **If you need mental health treatment, you are urged to call toll free (800) 274-7767, or in Nevada (800) 336-7767, for pre-authorization.**

- You do not have to sign up with a particular Physician or medical group and use them exclusively for your medical needs. You may use the services of a PPO provider whenever you choose to.

Why Should You Use PPO Providers?

.....because you and the Plan save money. In addition, you will know that the provider is contractually obligated to maintain certain standards.

Refer to the Summary of Benefits at the beginning of this booklet. As you can see from the summary, a higher percentage of your health care costs are payable if you use a PPO Provider. In addition, PPO Providers cannot charge you more for a Covered Service than what is allowed under the PPO contract. This means less out-of-pocket expense for you.

Questions????

If you have any questions about the PPO Program, please call the Administrative Office toll free at (800) 947-4338. The PPO directory can be found at www.anthem.com.

How a Physician or Hospital Can Join the PPO

If a physician or hospital wishes to join the PPO, they should send a letter of request to the Administrative Office. The Administrative Office will, in turn, forward the request to Anthem Blue Cross. Anthem Blue Cross will review the request and make the decision.

Patient Protection Rights under the Affordable Care Act

The Fee-For-Service PPO Medical option does not require the selection or designation of a primary care provider. You have the ability to visit any health care provider; however, payment may be less for the use of a Non-PPO provider.

You also do not need prior authorization from the Plan or from any other entity or person (including a primary care provider) in order to obtain access to obstetrical or gynecological care

from a health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Anthem Blue Cross at their website listed on the Quick Reference Chart.

IMPORTANT NOTES:

- *It is essential that you obtain your medical care from a PPO Provider whenever possible. If the services you receive could have been provided by a PPO Provider and were not, your benefits will be payable at a lower percentage except as provided in the next bullet.*
- *If you do not live within 20 miles of a PPO Provider, notify the Administrative Office so that your benefits will not be reduced for using a non-PPO Provider. This exception also applies to care in the event of an Emergency and to students while they are away at school and are not within 20 miles of a PPO Provider. The provider must certify that it is an Emergency. Please refer to the definition of Emergency in the Glossary.*
- *Not all providers treating patients in a PPO Provider Hospital's Outpatient Department are PPO Providers. Some providers may not be Hospital employees and may not be signed up with the PPO. Benefits will be paid at the non-PPO level for services provided by non-PPO Providers, even if the services are rendered in a PPO Provider Hospital, unless specifically authorized by the Plan.*
- *Not all PPO Physicians automatically refer their patients to PPO facilities when surgery, lab work, hospitalization, or other specialized treatment is necessary. So if you want to use a PPO facility, it is very important for you to tell your Physician that you want to be referred to a PPO provider.*

MEDICAL DEDUCTIBLE

Before most benefits described in this Chapter 2 become available, you must satisfy the Medical Deductible. **The Medical Deductible for Covered Services provided by PPO Providers is $300 per person each calendar year. The Medical Deductible for Covered Services provided by non-PPO Providers is $600 per person per calendar year**. Please note that effective January 1, 2018, the PPO and non-PPO deductibles are separate deductibles: this means that a charge applied to one deductible will not be applied to the other.

The Medical Deductible applies separately to each family member. However, no more than three Medical Deductibles per family will be required in a calendar year. The Medical Deductible is taken from Allowable Charges for Covered Services that are submitted to the Administrative Office. The Medical Deductible is satisfied once you have submitted Allowable Charges for Covered Services equal to the Medical Deductible amount. Your deductible can be met only from out-of-pocket Allowable Charges for Covered Services.

No Medical Deductible is required to be satisfied before the following benefits become available:

- Benefits for treatment of accidental injury if the charges are incurred within 72 hours of the injury;
- Benefits for Birthing Centers;
- Benefits for a Nurse-Midwife;
- Benefits for Preventive Care Services when provided by PPO Providers;
- Benefits for hearing aids.

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum applies only to services and supplies provided by PPO Providers. There is **no** Out-of-Pocket Maximum when services and supplies are provided by non-PPO Providers except for certain emergency care services provided in a non-PPO Hospital emergency room.

When the Out-of-Pocket Maximum is reached for a participant or dependent during a calendar year, benefits for that covered individual increase for Allowable Charges incurred during the remainder of the calendar year to 100% for Covered Services provided by PPO Providers.

The Out-of-Pocket Maximum is $3,400 for each individual but not more than a total of $6,800 per family. For a family, the most that any one individual pays for Covered Services is $3,400, and the most that the family will pay in total is $6,800. Out-of-pocket costs include amounts applied to the Medical Deductible, member co-insurance (based only on Allowable Charges), and co-payments (if any) for Covered Services except as provided below.

Not all out-of-pocket costs are used to determine if the Out-of-Pocket Maximum is reached. Not counted are:

- All non-PPO charges except for Emergency Care received in the emergency room of a non-PPO Hospital,
- Allowable Charges that are payable at 100%, such as birthing center charges,
- Allowable Charges that are subject to a specific benefit dollar limit, for example, benefits for hearing aids.

In addition to not being counted toward the Out-of-Pocket Maximum, benefits for the foregoing Allowable Charges do **not** increase to 100% once the Out-of-Pocket maximum is reached.

BENEFITS FOR COVERED SERVICES ***(Medical Deductible applies unless specifically stated otherwise)***

Hospital Inpatient Care: When you are confined in a Hospital as a registered bed patient for care of injury or illness (including substance abuse detoxification), payment will be made for Allowable Charges billed by the Hospital for Covered Services as follows:

PPO Provider Hospital.....	75%
Non-PPO Provider Hospital.....	50%

Covered Services include:

- semi-private room,
- intensive care and coronary care units; Allowable Charges for non-PPO Provider Hospitals are limited to a daily maximum of two and one-half times the Hospital's average semi-private room rate,
- definitive observation units; Allowable Charges for non-PPO Provider Hospitals are limited to a daily maximum of one and one-half times the Hospital's average semi-private room rate,
- pediatric intensive care units; Allowable Charges for non-PPO Provider Hospitals are limited to a daily maximum of two and one-half times the Hospital's average pediatric semi-private room rate, or, if there is no pediatric semi-private room rate, one and one-half times the Hospital's average neonatal rate,
- private room only if recommended by a Physician and the patient's medical condition warrants such confinement as determined by the Plan; Allowable Charges for non-PPO Provider Hospitals are limited to a daily maximum of one and one-half times the Hospital's average semi-private room rate,
- medically necessary ancillary services and supplies; this does not include personal items such as television, telephone, personal hygiene items, and guest trays; however, one Hospital admission kit per confinement will be covered.

Limitations on Hospital Inpatient Care

In addition to the Fee-For-Service PPO Medical Exclusions listed later in this Chapter, and the General Limitations and Exclusions listed in Chapter 7, benefits for Hospital Inpatient care are limited as follows:

- If pre-admission testing is performed on an inpatient basis in a non-PPO Provider Hospital or PPO Provider Hospital, Hospital room and board charges for the day of testing will be covered only if the confinement was an Emergency;

- If a late discharge from the Hospital is necessary and is authorized by your Physician, the Allowable Charges for the day of your discharge will be one-half of the Hospital's daily charge;

- Equipment and supplies purchased through a Hospital for home use only are not covered;

- No benefits are payable for services in connection with transplants unless pre-authorized and managed by Anthem Blue Cross.

Hospital Outpatient Care: When you are not confined in a Hospital as a registered bed patient but receive care for injury or illness, payment will be made for Allowable Charges billed by the Hospital for Covered Services as follows:

PPO Provider Hospital.....	75%; an additional $75 co-payment per visit applies to emergency room services unless the patient is admitted as an inpatient directly from the emergency room
Non-PPO Provider Hospital.....	50% for non-emergency room care; 75% for emergency room care after a $75 co-payment per visit ($75 co-payment is waived if the patient is admitted as an inpatient directly from the emergency room)

Covered Services include:

- pre-admission or diagnostic tests,

- non-Emergency medical care which cannot ordinarily be performed in a Physician's office,

- Emergency medical care,

- surgical care.

Limitations on Hospital Outpatient Care

In addition to the Fee-For-Service PPO Medical Exclusions listed later in this Chapter and the General Limitations and Exclusions listed in Chapter 7, benefits for Hospital Outpatient Care are limited as follows:

- Allowable Charges for non-Emergency medical care that normally can be performed in a Physician's office are limited to the amounts that would have been allowed had the medical care been performed in a Physician's office;

- Hospital emergency room benefits will only be provided if an Emergency exists – see Glossary for definition of an Emergency; see also the definition of Allowable Charges related to how the Plan determines amounts payable for a medical Emergency in a Hospital emergency room;

- Equipment and supplies purchased through a Hospital for home use only are not covered;

- All-inclusive or global fees billed by a non-PPO Provider Hospital will be broken down by the Administrative Office for each service or supply provided, and benefits will be calculated based on the broken down fees; in the absence of an itemized billing, the Administrative Office will use a percentage allocation method for processing the claim.

IMPORTANT NOTE ON OUTPATIENT SURGERIES AND AMBULATORY CENTER CARE

In the past, health plans often encouraged participants to have surgery performed on an outpatient basis when medically appropriate because it was less costly than an overnight confinement in a Hospital. However, many Hospitals and outpatient surgical centers have tried to take advantage of that by charging enormous and creative fees for outpatient surgery. Therefore, the Plan has had to respond by auditing bills for outpatient surgeries.

Based on the Plan audit, some charges may be disallowed because they are determined to be excessive. In order to avoid being shocked by a large out-of-pocket charge for which you may be personally liable, you should ask the Hospital or Ambulatory Center for a fee estimate if you will be undergoing surgery in the outpatient department of a Hospital or surgical center. Submit that estimate to the Administrative Office prior to undergoing surgery. The fee estimate will be reviewed for the proposed services and you will be advised of whether the fee estimate falls within allowable limits under the Fee-For-Service PPO Medical option. Of course, you should always call Anthem Blue Cross for pre-authorization and use a PPO facility whenever possible.

Ambulatory Center (Surgicenter) Care: When you receive treatment from an Ambulatory Center for care of injury or illness, payment will be made for Allowable Charges billed by the Ambulatory Center for Covered Services as follows:

PPO Provider	75%
Non-PPO Provider	50%

Covered Services include:

- pre-admission or diagnostic tests,

- non-surgical medical care,

- surgical care; Allowable Charges for facility usage in surgical cases are subject to audit on the same basis as surgical care provided in the outpatient department of a Hospital as described in the box above.

Note that all-inclusive or global fees billed by a non-PPO Ambulatory Center will be handled as described under Limitations on Hospital Outpatient Care above. Also, please be aware that not all PPO Physicians automatically refer their patients to PPO facilities when surgery, hospitalization, or other specialized treatment is needed. So if you want to use a PPO facility, it is important for you to discuss this with your Physician.

Physician Care: When you receive treatment from a Physician for diagnosis or care of injury or illness, payment will be made for Allowable Charges billed by a Physician for Covered Services as follows:

Surgery	
PPO Physician.....	75%
Non-PPO Physician	50%
Hospital, Office or Home Visits	
PPO Physician.....	75%
Non-PPO Physician	50%

If an assistant surgeon or stand-by services are required, as determined by the Plan, during a surgical procedure for which benefits are payable, benefits will be payable for Allowable Charges at the same percentage that is payable for the surgeon's fees.

Limitations on Physician Care Benefits

In addition to the Fee-For-Service PPO Medical Exclusions listed later in this Chapter and the General Limitations and Exclusions listed in Chapter 7, benefits for Physician Care are limited as follows:

- The maximum amount payable for assistant surgery services performed by a non-PPO Physician (M.D.) is an amount equal to 20% of the payment for the primary surgeon's services. The maximum amount payable for assistant surgery services performed by a non-PPO Recognized Provider" other than a Physician (M.D.) is an amount equal to 10% of the payment for the primary surgeon's service. Refer to the Glossary section of this booklet for the definition of Recognized Provider;

- For surgery performed in a non-PPO Physician's Office, Allowable Charges for facility usage and necessary supplies furnished in connection with the surgery are limited to a maximum amount equal to 30% of the amount allowed for performing the surgery;

- Any care for which benefits are provided under other provisions of the Fee-For-Service PPO Medical option are not payable under this Physician Care benefit (e.g., Physical Therapy, etc.);

- No benefits are payable for services in connection with transplants unless pre-authorized and arranged by Anthem Blue Cross.

Second Surgical Opinion: In the event you have been advised, or otherwise want, to obtain a second opinion from a Physician on the need for a proposed surgical procedure, you are encouraged to obtain pre-authorization from Anthem Blue Cross prior to obtaining the second surgical opinion. If the second surgical opinion is pre-authorized, 100% of the Allowable Charges for the second opinion will be payable, including any necessary diagnostic services or tests directly in connection with the rendering of the second surgical opinion. If a third opinion is necessary and pre-authorized by Anthem Blue Cross, the cost of the third surgical opinion will

also be covered at 100% of Allowable Charges. If pre-authorization is not obtained from Anthem Blue Cross, regular benefits will be provided (generally 75% of Allowable Charges for PPO Providers or 50% for non-PPO Providers).

Extended Care or Rehabilitation Facility Confinement: When you are confined in an Extended Care or Rehabilitation Facility for continued care of, or rehabilitation from, injury or illness (this does not include Custodial Care), benefits are payable at 75% of Allowable Charges billed by a PPO facility for room, board and medically necessary ancillary services and supplies. The percentage payable for a non-PPO facility is 50%. Benefits are payable for a maximum of 60 days per calendar year. The Extended Care or Rehabilitation Facility confinement must begin within 14 days following a period of at least 3 days of acute care Hospital confinement for the same condition.

Limitations on Extended Care and Rehabilitation Facility Confinement

In addition to the Fee-For-Service PPO Medical Exclusions listed later in this Chapter, and the General Limitations and Exclusions listed in Chapter 7, benefits for Extended Care or Rehabilitation Facility confinement are limited as follows:

- Allowable Charges for room, board, and general nursing care are limited to the facility's average charge for a semi-private room;

- Confinement primarily for Custodial Care is not covered.

Physical Therapy: When you receive Covered Services from a Physician or as prescribed by a Physician, from a Recognized Provider, for short-term physical therapy or cardiac rehabilitation treatment, payment will be made for Allowable Charges as follows:

PPO Provider	75%
Non-PPO Provider	50%

Limitations on Physical Therapy Benefits

In addition to the Fee-For-Service PPO Medical Exclusions listed later in this Chapter and the General Limitations and Exclusions listed in Chapter 7, physical therapy benefits are limited as follows:

- Physical therapy benefits are available only for short-term, active and progressive therapy that is rehabilitative in nature. The number of physical therapy visits allowable under the Plan is dependent upon the patient's diagnosis and prognosis. Therapy that extends beyond 32 visits in a six-month period is, under most circumstances, not covered.

- Long-term maintenance therapy and group exercise programs are not covered.

Speech Therapy: When you receive Covered Services from a Physician or upon the referral of a Physician, from a Recognized Provider, payment will be made for Allowable Charges as follows:

PPO Provider	75%
Non-PPO Provider	50%

Vision Therapy: When you receive Covered Services from a Physician or Recognized Provider for vision therapy, which is performed in lieu of surgery, as determined by the Plan, payment will be made at 100% of Allowable Charges up to a maximum payment of $45 per visit regardless of whether the provider is a PPO or Non-PPO Provider.

If you plan to undergo vision therapy, you should get pre-authorization from the Plan because this type of therapy requires medical review to determine whether it will be covered under the terms of the Fee-For-Service PPO Medical option. Call the Administrative Office for details.

Hormone Therapy: When an eligible dependent child receives Covered Services from a Physician, payment will be made for Allowable Charges as follows:

PPO Provider	75%
Non-PPO Provider	50%

The above benefits are also payable for hormone therapy provided to participants or dependents with post-menopausal syndrome (PMS) if a Physician renders such therapy.

Limitations on Hormone Therapy Benefits

In addition to the Fee-For-Service PPO Medical Exclusions listed later in this Chapter and the General Limitations and Exclusions listed in Chapter 7, hormone therapy benefits are provided to dependent children only if they meet certain medical criteria. Therefore, it is strongly recommended that you call Anthem Blue Cross at (800) 274-7767, or in Nevada (800) 336-7767, before therapy begins, to determine if your child meets the necessary medical criteria to qualify for hormone therapy benefits.

Home Health Care: When you receive Covered Services for home health care of injury or illness, including, but not limited to nursing care, home infusion therapy, home respiratory services and physical therapy, payment will be made for Allowable Charges as follows:

PPO Provider	75%
Non-PPO Provider…….....	50%

All home health care should be pre-authorized.

Limitations on Home Health Care Benefits

In addition to the Fee-For-Service PPO Medical Exclusions listed later in this Chapter and the General Limitations and Exclusions listed in Chapter 7, benefits for Home Health Care are limited as follows:

- Nursing care is limited to professional services of a Registered Nurse or licensed vocational nurse.

- A Physician must prescribe nursing care. The Physician's prescription should include the number of hours per day that nursing care is required, the number of days per week and the level of nursing skills required.

- Covered Services rendered by a nurse must require the skill and training of that type of nurse.

- Custodial Care is not covered.

Chiropractic Care: When you receive Covered Services from a licensed chiropractor, payment will be made at 100% of allowable charges up to a maximum benefit of $40 per visit regardless of whether the provider is a PPO or Non-PPO Provider. Benefits for manipulations of the musculoskeletal system, physical therapy, or any other therapy rendered by a licensed chiropractor will be payable under this Chiropractic Care benefit subject to the benefit maximum stated in this section.

Limitations on Chiropractic Care Benefits

In addition to the Fee-For-Service PPO Medical Exclusions listed later in this Chapter and the General Limitations and Exclusions listed in Chapter 7, chiropractic care benefits are limited as follows:

- Chiropractic care benefits are available only for short-term, active, and progressive therapy that is rehabilitative in nature;

- Long-term maintenance therapy and group exercise programs are not covered.

Acupuncture: When you receive Covered Services from a Recognized Provider for acupuncture treatment, payment will be made at 100% of Allowable Charges up to a maximum payment of $35 per visit regardless of whether the provider is a PPO or Non-PPO Provider.

Psychiatric Care: When you receive Covered Services from a Hospital, licensed residential treatment facility or Recognized Provider for psychiatric care, benefits will be provided on the same basis as any other illness. This means, generally, that payment will be made for Allowable Charges as follows:

PPO Provider	75%
Non-PPO Provider	50%

Coverage includes hospitalization (either under a full-time or partial confinement treatment program), residential treatment care' and professional services of a Recognized Provider.

Limitations on Psychiatric Care

In addition to the Fee-For-Service PPO Medical Exclusions listed later in this Chapter and the General Limitations and Exclusions listed in Chapter 7, benefits for Psychiatric Care are limited as follows:

- Benefits are not payable for vocational rehabilitation programs;

- Benefits are not payable for marriage or sex counseling;

- Benefits are not payable for psychiatric care in connection with alcoholism, substance addiction, or substance abuse (refer below for benefits).

Substance Abuse Rehabilitation Treatment: ***Pre-authorization is recommended for this benefit. Before you undergo any rehabilitation treatment, you should call Beat-It toll free at (800) 828-3939 so appropriate care can be pre-authorized and arranged.*** When you receive Covered Services from a Hospital, licensed residential treatment facility or Recognized Provider for substance abuse rehabilitation treatment, benefits will be provided on the same basis as any other illness. This means, generally, that payment will be made for Allowable Charges as follows:

PPO Provider	75%
Non-PPO Provider	50%

Coverage includes hospitalization (either under a full-time or partial confinement treatment program), residential treatment care and professional services of a Recognized Provider.

Limitations on Substance Abuse Treatment

In addition to the Fee-For-Service PPO Medical Exclusions listed later in this chapter and the General Limitations and Exclusions listed in Chapter 7, Substance Abuse Rehabilitation Treatment benefits are limited as follows:

- Benefits are not payable for vocational rehabilitation programs;

- Benefits are not payable for marriage or sex counseling.

Ambulance Service: When you are transported by a professional ambulance service either from the scene of an accident or illness to the nearest appropriate treatment facility equipped to furnish treatment of the injury or illness, or from one treatment facility to another treatment facility upon the written request of a Physician, payment will be made at 75% of Allowable Charges up to a maximum payment per trip of $1,000 for ground transportation including mileage, or $10,000 plus $100 per mile if an air ambulance is used.

Use of an air ambulance must be deemed medically necessary by the Plan in order for benefits to be paid. Payment maximums do not include Allowable Charges for ancillary services rendered during transportation. The transportation must be Medically Necessary and not merely for the convenience of the patient, family, or Physician.

Hospice Care: When you receive Covered Services in connection with Hospice Care (as defined in the Glossary), payment will be made at 75% of Allowable Charges.

Maternity Care: (**This benefit IS NOT provided to dependent children except items covered under the Preventive Care Services Benefit described later in this chapter.**) When you receive Covered Services in connection with pregnancy, payment will be made on the same basis

as an illness with the following exceptions:

Exceptions:

- When you receive Covered Services at a Birthing Center (as defined in the Glossary), payment will be made for the center, prenatal care, and follow-up care, at 100% of Allowable Charges. Benefits are limited to a maximum payment of $1,500 per pregnancy. Benefits are payable regardless of whether or not your Medical Deductible is satisfied.

- When you receive Covered Services from a Nurse-Midwife (as defined in the Glossary), payment will be made at 100% of Allowable Charges up to maximum payment of $750 per pregnancy. Benefits are payable regardless of whether or not your Medical Deductible is satisfied.

- The newborn baby will be covered from birth if Plan A's enrollment requirements are met, and the Hospital's charges for routine care of the baby are considered the mother's expense for purposes of benefit determination.

- Maternity and obstetrical benefits are provided only for Covered Services incurred while the patient is covered under the Fee-For-Service PPO Medical option. However, it is not necessary to be covered at the time of conception.

- The following items are covered for all females under the Preventive Care Services Benefit described in this Chapter: Pre-natal and post-natal care; and breastfeeding support, supplies, rental of equipment, and counseling.

The Plan complies with federal law that prohibits restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or requiring a health care practitioner to obtain authorization from the Plan (or its utilization review company) for prescribing a length of stay not in excess of those periods.

Preventive Care Services: When you receive Preventive Care Services (described below), benefits are payable for Allowable Charges as follows:

PPO Provider ..... 100%; *Medical Deductible waived*
Non-PPO Provider ..... 50%; *Medical Deductible NOT waived*

Preventive Care Services include services with an "A" or "B" rating from the U.S. Preventive Services Task Force, immunizations recommended by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices, and with respect to infants, children, adolescents, and women, additional preventive care and screenings provided for in guidelines supported by the U.S. Department of Health and Human Services' Health Resources & Services Administration.

Preventive Care Services also include pre-natal and post-natal care for all females, breastfeeding support, supplies, rental of equipment, and counseling, and all FDA-approved contraceptive methods for women. **Ultrasounds and delivery fees for a pregnant dependent child are not covered.**

An office visit to a Physician will be considered a Preventive Care Service if the primary purpose for the visit is the delivery of a Preventive Care Service and no separate charge is made for the Preventive Care Service provided during the visit.

For further information, visit the following websites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits,
- http://www.cdc.gov/vaccines/schedules/hcp/index.html,
- http://www.uspreventiveservicestaskforce.org/BrowseRec/Index, and
- http://www.hrsa.gov/womensguidelines/

Preventive care services required to be covered in accordance with health care reform under the Affordable Care Act, are periodically updated by the government agencies.

IMPORTANT – The claim form or billing prepared by the Physician's office must indicate that the services performed were Preventive Care Services in order for benefits to be paid as stated above.

Organ and Tissue Transplants: Organ and tissue transplant care and treatment must be pre-authorized, and arranged and managed through Anthem Blue Cross, or benefits will not be payable under any circumstances (refer to page 33). When you receive authorized Covered Services in connection with an organ transplant, payment will be made for Allowable Charges on the same basis as any other illness. However, your care must be under Anthem Blue Cross's case management; otherwise no benefits are provided. Benefits for Allowable Charges incurred by an organ donor are limited to a maximum payment of $50,000 per transplant. Other limitations apply to organ donors; refer to the General Limitations and Exclusions in Chapter 7.

Hearing Aids: When you obtain a hearing aid device from a Recognized Provider, payment will be made at 100% of Allowable Charges for the device, it's fitting, and the hearing test up to a combined maximum payment of $1,000 for each device. Benefits are payable regardless of whether or not your Medical Deductible is satisfied.

Limitations on Hearing Aid Benefits

In addition to the Fee-For-Service PPO Medical Exclusions listed later in this chapter and the General Limitations and Exclusions listed in Chapter 7, Hearing Aid benefits are limited as follows:

- Benefits are not payable for more than one hearing aid device for each ear in a three-year period;

- Benefits are not payable for cleaning, repair, or maintenance of hearing aids;

- Benefits are not payable for replacement of a lost, stolen, or broken hearing aid except when benefits would otherwise be available.

Durable Medical Equipment: ***Pre-authorization is recommended for this benefit. If you***

believe you will need durable medical equipment, call Anthem Blue Cross at (800) 274-7767, or in Nevada (800) 336-7767, for pre-authorization and referral.

Benefits are payable for Allowable Charges for the rental of durable medical equipment up to the reasonable purchase price of the equipment as follows:

PPO Provider	75%
Non-PPO Provider	50%

Benefits may be payable (at the percentage shown above) for the purchase of durable medical equipment, including maintenance agreements, if the Plan determines that it is cost effective. The amount of benefits payable for the purchase of durable medical equipment will be reduced by any benefits paid for the rental of such equipment.

Durable medical equipment is equipment that:

- can withstand repeated use,
- is primarily and customarily used to service a medical purpose,
- is generally not useful to a person in the absence of injury or sickness, and
- is appropriate for use in the home.

Benefits for the rental or purchase of durable medical equipment are limited to the standard item of the equipment as determined by the Plan. Costs associated with the customization or personalization of durable medical equipment, and, comfort, convenience or luxury equipment, is not covered. Additionally, items purchased from a Hospital for home use are not covered.

Other Covered Services: When you receive any of the Covered Services listed below from a Recognized Provider for care or treatment of injury or illness, payment will be made at 75% of Allowable Charges. However, if a PPO Provider is available but not used, payment will be made at 50% of Allowable Charges.

- Diagnostic x-rays and laboratory tests;

- Radiation therapy and chemotherapy;

- Kidney dialysis (it is important that individuals with end stage kidney/renal disease (ESRD) promptly apply for Medicare coverage, regardless of age);

- Routine patient costs for items and services furnished in connection with participation in an approved clinical trial if those items and services are otherwise covered by the Fee-For-Service PPO Medical option absent participation in an approved clinical trial;

- Blood or blood plasma for which you are required to pay or, in the case of blood provided by the patient or by a directed donor, charges in connection with the donation or storage of blood are covered up to a maximum Allowable Charge equal to the amount that would be charged by the American Red Cross for each such unit of blood;

- Oxygen and the rental of equipment for the administration of oxygen;

- Orthotic devices that improve or support the function of an impaired or weakened body part such as binders, braces, or crutches;

- Prostheses, including breast implants or prosthesis with surgical brassiere; benefits are limited to a maximum payment of $10,000 per device; benefits are payable for medically necessary repair, adjustment, and servicing of prosthetic devices; replacement of a prosthetic device is payable when the patient experiences a change due to their physical condition or due to the fact that the prosthetic device cannot be satisfactorily repaired (benefits are limited to a maximum payment of $10,000 per replacement device); the preceding dollar limitations do not apply to breast prosthetics in connection with a mastectomy. Refer to page 36 for "SPECIAL PROVISIONS REGARDING WOMEN'S HEALTH CARE";

- Wig for hair loss replacement due to chemotherapy or radiation treatment;

- Sterilization procedures and their reversal;

- Medically necessary treatment of a temporomandibular joint (TMJ) dysfunction if not orthodontic in nature, up to an Allowable Charge per splint device of $550 if it is removable or $600 if it is a fixed device. Replacement devices, surgery, anesthesia, and other professional services should be pre-authorized by the Plan;

- Therapeutic abortion;

- Breast reconstruction following a mastectomy including surgery and reconstruction of the other breast to produce a symmetrical appearance and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

EXCLUSIONS

In addition to the General Limitations and Exclusions listed in Chapter 7, Fee-For-Service PPO Medical option benefits are not payable for any expense incurred in connection with:

- Cosmetic Surgery or Treatment and any complications arising from such surgery or treatment, except:
  - to correct damage resulting from an accident,
  - to correct a functional disorder or congenital malformation, or
  - breast reconstruction following a mastectomy;

- refractive eye surgery to improve nearsightedness, farsightedness, or astigmatism by changing the shape of the cornea including, but not limited to, Lasik, radial keratotomy, and keratomileusis surgery except where medically necessary and where there are no other viable alternatives as determined in the sole and absolute discretion of the Plan;

- treatment of flat feet or Cosmetic Treatment of the feet, including orthotics in connection with such treatment;

- dental care (refer to the Plan A dental options for coverage) including treatment of the teeth

or gums except:

- treatment for accidental injury to teeth due to an accident,
- surgical treatment of gum tumors,
- removal of impacted wisdom teeth when surgery is performed by a Physician (dental surgeon), or
- TMJ oral splint device;

- eye refractions, eyeglasses, or contact lenses, or the fitting of eyeglasses or contact lenses (refer to the Plan A vision care plan for coverage);

- vocational rehabilitation programs, recreation therapy, massage therapy, health club membership, or other non-medical self-care or self-help training;

- treatment of a temporomandibular joint (TMJ) dysfunction that is orthodontic in nature except coverage is provided for a TMJ oral splint device;

- treatment for weight reduction, gain, or control, except intensive behavioral counseling for overweight or obese individuals under the Preventive Services Benefit and surgery is covered if the patient's condition is morbid obesity or as otherwise required by federal law. Morbid obesity means a body mass index (BMI) exceeding 40 or a BMI greater than 35 in conjunction with any of the following severe comorbidities:

  - coronary heart disease;
  - type 2 diabetes mellitus;
  - clinically significant obstructive sleep apnea (as determined by the Plan or its designee); or
  - high blood pressure/hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management);

  BMI is calculated by dividing the individual's weight (in kilograms) by height (in meters) squared.

  You are urged to call Anthem Blue Cross for pre-authorization at (800) 274-7767, or in Nevada (800) 336-7767, before undergoing surgery so you will know if you qualify for morbid obesity benefits;

- chelation therapy except in cases of lead poisoning;

- treatment of infertility, including, but not limited to, artificial insemination, in-vitro fertilization, and hormone therapy; however, reversals of sterilization procedures are covered and services and supplies for the **diagnosis (but not treatment)** of infertility are covered;

- elective genetic testing or counseling;

- vitamins and all prescription drugs or medications dispensed outside a Hospital or Extended Care/Rehabilitation Facility (refer to the Prescription Drug Benefits in Chapter 3 for coverage);

- surrogate pregnancy;
- marital, family, or sex counseling;
- eating disorders;
- alopecia (hair loss) except for a wig for hair loss due to chemotherapy or radiation treatment;
- personal items. One admission kit per Hospital confinement is allowed. Charges for telephone, television, etc. are not covered;
- equipment or supplies purchased through a Hospital for home use only;
- ambulance transportation which is primarily for the convenience of the patient, family, or Physician;
- Custodial Care (except as specially provided by the Hospice Care benefit) or confinement in a rest home, home for the aged, nursing home, or convalescent home;
- nursing care for which the expertise of a trained nurse (Registered Nurse or licensed vocational nurse) is not required, or which is determined by the Plan to be not medically necessary except as specifically provided by the Hospice Care benefit;
- late discharge from a Hospital or other such facility unless it is determined by the Plan to be medically necessary and is authorized by the attending Physician;
- blood or blood plasma for which you are not required to pay;
- any bodily injury or sickness for which the person for whom the claim is presented is not under the care of a Physician unless otherwise stated in this booklet;
- equipment for environmental control or general household use such as air conditioners, air purifiers, dehumidifiers, food liquidizers, water bottles, water beds, swimming pools, hot tubs, exercise and health equipment, and any other clothing or equipment which could be used in the absence of an illness or injury;
- complications arising from any non-covered surgery or treatment; and
- services of a surgical assistant when the patient or the surgery does not warrant the use of a surgical assistant or when the surgical assistant receives remuneration by the Hospital such as a surgical resident or house staff Physician.

PROVIDER NONDISCRIMINATION

In accordance with the Affordable Care Act, to the extent an item or service is a covered benefit under the Fee-For-Service PPO Medical option, and consistent with reasonable medical

management techniques with respect to the frequency, method, treatment, or setting for an item or service, the Plan will not discriminate with respect to participation under the Fee-For-Service PPO Medical option or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. The Plan is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by the Plan. The Plan is permitted to establish varying reimbursement rates based on quality or performance measures.

HOW TO FILE A CLAIM UNDER THE FEE-FOR-SERVICE PPO MEDICAL OPTION

For Hospital Benefits: Remember to call (800) 274-7767, or in Nevada (800) 336-7767, at least 72 hours before going into the hospital. At the time of pre-admission testing or Hospital admission, a Hospital admissions office will contact the Administrative Office to verify your eligibility and Hospital benefits. You should submit a completed claim form to the Hospital admissions office. In most cases, the Hospital will submit your claim for you. If the Hospital notifies you that they do not bill your insurance, you will be responsible to submit the itemized bill to Anthem Blue Cross.

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

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

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

Where to Obtain Claim Forms

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

Where to File a Claim

Anthem Blue Cross
Attention: Repricing Department
P.O. Box 60007
Los Angeles, CA 90060-0007

Note: If you are covered under more than one benefit plan, refer to the Coordination of Benefits section in Chapter 5 to determine where you should file your claim first.

Medical Assignment

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

Medical Payment Estimates

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

Using an Authorized Representative

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

CHAPTER 3 – OUTPATIENT PRESCRIPTION DRUG BENEFITS UNDER THE FEE-FOR SERVICE PPO MEDICAL OPTION

The provisions and benefit descriptions in this Chapter apply to participants and eligible dependents enrolled in the Plan A Fee-For-Service PPO Medical option. If you are enrolled in an HMO or EPO, you should refer to the benefit booklet (Evidence of Coverage) issued by the HMO or EPO for your medical and prescription drug coverage.

In this Chapter you'll find:

- **Benefits**
- **Out-of-pocket maximum**
- **Prescription quantity**
- **Covered drugs**
- **Exclusions**
- **How to use the retail program**
- **How to use the mail service program**
- **Information on specialty medications**
- **How to reach the prescription drug administrator**

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

BENEFITS

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

Location	Copayment You Pay For Each Prescription Filled Or Refilled	Type of Drug
Participating Retail Pharmacy Location	$10	Generic drug
	$30	Preferred brand name drug
	$45	Non-preferred brand name drug
Mail Order (Home Delivery) Service	$15	Generic drug
	$45	Preferred brand name drug
	$68	Non-preferred brand name drug
Specialty Pharmacy (Accredo)	$10	Specialty drug

WHAT IS A PREFERRED DRUG?

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

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum under the Fee-For-Service Outpatient Prescription Drug Benefit is $3,200 per person per calendar year, and $6,400 per family per calendar year. This means that coverage will be provided at 100% of Allowable Charges once the amount that any individual pays for covered prescription drugs reaches $3,200 in a calendar year. For a family, the most that any one individual pays for covered prescription drugs is $3,200 per calendar year and the most that the family will pay in total is $6,400 in a calendar year.

PRESCRIPTION QUANTITY

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

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

COVERED DRUGS

- All medications and contraceptive devices or injectables which under federal or California law require the written or oral prescription of a licensed Physician, except those listed under

"Exclusions."

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

- Certain over-the-counter (OTC) drugs as required by federal law and as shown in the following table, if prescribed by a Physician and obtained at a retail participating pharmacy or through the mail order program. Where the information in the following table conflicts with newly released health reform regulations under the Affordable Care Act affecting the coverage of OTC drugs, this Prescription Drug Benefit will comply with the new requirements on the date required.

  Where coverage is provided, no cost-sharing is required by you unless otherwise stated below, provided the following payment parameters are met.

OTC Drug Name	Who Is Covered for this Drug?	Payment Parameters for Generic OTC Drugs
Aspirin	• For men 45-79 years of age to reduce chance of a heart attack. • For women 55-79 years of age to reduce the chance of a stroke. • For pregnant women who are at high risk for preeclampsia (a pregnancy complication).	For non-pregnant adults: since dosage is not established by USPSTF, Plan covers up to one bottle of generic 100 tablets every 3 months. Daily low-dose aspirin (81 mg) as preventive medication after 12 weeks' gestation in pregnant women who are at high risk for preeclampsia.
OTC Contraceptives for females, such as spermicidal products and sponges	All females	Up to a month's supply of prescription contraceptives per purchase (or 3-month supply of certain 90-day dosed contraceptives like Seasonale) are payable under the Prescription Drug Program [for females younger than 60 years of age]. Generic FDA approved contraceptives are at no cost to the Plan participant. Brand contraceptives are payable only if a generic alternative is medically inappropriate.
Folic acid supplements containing 0.4 - 0.8mg of folic acid	All females planning or capable of pregnancy should take a daily folic acid supplement.	Excludes women over 55 years of age, and products containing greater than 0.8mg or less than 0.4mg of folic acid.

OTC Drug Name	Who Is Covered for this Drug?	Payment Parameters for Generic OTC Drugs
		Generic folic acid up to one tablet per day is covered.
Iron supplements	For children ages 6-12 months who are at increased risk for iron deficiency.	OTC coverage excludes intravenous iron products and bulk iron products. Regular copays apply.
Vitamin D supplements	For adults age 65 and older who are at increased risk for falling.	Since dosage is not established by USPSTF, up to one bottle of generic 100 tablets every 3 months is covered
Tobacco cessation products (FDA approved)	Individuals who use tobacco products.	FDA-approved tobacco cessation drugs (including both prescription and over-the-counter medications) are payable under the Prescription Drug Program, for up to two 90-day treatment regimens per year, which applies to all products. No precertification or prior authorization is required.
Fluoride supplements	For preschool children older than age 6 months through 5 years of age when recommended by provider because primary water source is deficient in fluoride.	Coverage is provided for generic versions of systemic dietary fluoride supplements (tablets, drops, or lozenges) available only by prescription for children to age 6 years. Excludes products for individuals age 6 and older, topical fluoride products like toothpaste or mouthwash, and excludes brand name fluoride supplements.
Preparation "prep" Products for a Colon Cancer Screening Test	For individuals receiving a preventive colon cancer screening test	Coverage is provided for the over-the-counter or prescription strength products prescribed by a Physician as preparation for a payable preventive colon cancer screening test, such as a colonoscopy for individuals age 50-75 years. Two fills per 365 days are covered.

EXCLUSIONS

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

- drugs or medicines not requiring a Physician's prescription, except items listed under Covered Drugs when prescribed by a Physician;

- blood and blood plasma, immunization agents, or biological sera;
- drugs for hair removal or replacement, such as Rogaine or Vaniga;
- Retin-A except for treatment of acne vulgaris;
- over-the-counter vitamins (except as required by federal law), cosmetics, dietary supplements, health and beauty aids;
- weight control medication;
- drugs or medications in connection with the treatment of infertility;
- non-drug items such as therapeutic devices or appliances, surgical garments, and surgical dressings;
- drugs not yet approved by the FDA. New FDA-approved drugs are covered unless the class of drug is excluded.

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

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

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

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

Maintenance drugs should be dispensed through the mail service pharmacy. Maintenance drugs are prescription drugs taken on a regular or long-term basis. First Class U.S. Mail or a national mail courier service like UPS delivers your prescription drugs directly to your home.

Points of Home Delivery

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

- Easy Rx Faxing for prescriber only (Fax# 800.837.0959)
- Call in a prescription for prescriber only (Phone # 888.327.9791, Prompt #2)

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

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

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

SPECIALTY MEDICATIONS

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

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

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

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

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

HOW TO REACH THE PRESCRIPTION DRUG BENEFIT ADMINISTRATOR

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

CHAPTER 4 - DEATH BENEFITS AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

The benefits described in this Chapter apply regardless of which medical option is selected. However, no one extending coverage under COBRA has this coverage unless a previous conversion is in effect (see Conversion of Participant Death Benefit in this Chapter).

In this Chapter you'll find:

- **Death benefits for participants**
- **Conversion of death benefits for participants**
- **Death benefits for dependents**
- **Accidental death and dismemberment benefits for participants**
- **Exclusions for accidental death and dismemberment benefits for participants**
- **How to file a claim**

DEATH BENEFITS FOR PARTICIPANTS

If a participant dies while covered under this Death Benefit, his or her designated beneficiary will be paid $20,000.

If the participant does not select a beneficiary or if his or her beneficiary does not live to receive payment, the beneficiary will be the surviving person or persons in the first of the following classes of successive preference beneficiaries of which a member survives to receive payment:

- the participant's legal spouse,
- children, including legally adopted children,
- parents,
- brothers and sisters,
- executor or administrator of the participant's estate.

If two or more persons are entitled to benefits, they will share equally, unless the participant has designated otherwise.

The beneficiary will be the person or persons named by the participant in the most recent beneficiary designation which the participant has completed in writing and which has been placed on file in the records of the Administrative Office. A participant may change his or her beneficiary at any time by submitting a written request to the Administrative Office. Notification of a divorce does not change your beneficiary. To change your beneficiary, you must submit a specific request for the change, and the request must be in writing. Participants cannot assign their death benefits. Beneficiaries must be natural persons or a qualified trust.

If a participant dies during the 31 days after his eligibility for this benefit terminates, the $20,000 death benefit will be paid even if the participant has not applied for conversion coverage as explained below.

CONVERSION OF PARTICIPANT DEATH BENEFITS

If a participant's eligibility for this benefit terminates, the participant may continue his or her $20,000 death benefit coverage on a self-payment basis. This self-payment continuation is separate from COBRA coverage.

If you want to continue the $20,000 death benefit coverage you must separately apply for the continuation and remit the first **two** months' self-payment (by check or money order) to the Administrative Office within 31 days following the date your eligibility terminates.

Example:	*If your eligibility terminates on June 30, you must submit your continuation form and self-payment for the months of July and August to the Administrative Office by July 31.*

Contact the Administrative Office for the continuation form and the current monthly self-payment amount. Continuation forms and/or initial self-payments received by the Administrative Office after this deadline will be rejected as untimely and will not be accepted.

After your initial two months' self-payment is made, subsequent self-payments are due monthly by the 20th day of the month before each consecutive coverage month. Failure to make the required self-payment by the due date will result in automatic termination of coverage. Once coverage is terminated it cannot be reinstated. The Administrative Offices does not send monthly bills or warning notices. It is your responsibility to submit self-payments when due.

The monthly self-payment amounts are determined by the Board of Trustees and are not guaranteed for any specific time period and they may be changed from time to time at the sole and absolute discretion of the Board of Trustees.

If a participant dies during the 31 days after the participant's eligibility for benefits under the Plan terminates, the $20,000 death benefit will be paid even if the participant has not applied for conversion coverage.

Important note: You are not eligible to apply for or maintain continuation coverage, and the 31-day death benefit extension described above will not apply, if your eligibility is lost because of delinquent owner-operator status or working in Non-Covered Sheet Metal Service.

DEATH BENEFITS FOR ELIGIBLE DEPENDENTS

If an eligible dependent spouse or child (from birth to age 19) dies while covered under this Death Benefit, the participant will be paid $2,000. Dependent children 19 years of age or older are not covered under this benefit, regardless of whether they meet the Plan's eligibility requirements for other coverage.

If the participant does not live to receive payment, the payment will be made to the surviving person or persons in the first of the following classes of successive preference beneficiaries of which a member survives to receive payment:

- the participant's legal spouse,
- children, including legally adopted children,
- parents,
- executor or administrator of the participant's estate.

If two or more persons are entitled to benefits, they will share equally.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS FOR PARTICIPANTS

Accidental Death and Dismemberment Benefits will be paid for any of the following losses caused solely through accidental means, on or off the job. The injury must be sustained while the participant is covered and the loss must occur within 90 days after such injury.

Loss of life $20,000
(paid to participant's designated beneficiary for the death benefit)

Loss of: Both hands or feet, or
Sight in both eyes, or
One hand and one foot, or
One hand and sight in one eye, or
One foot and sight in one eye..... $20,000
(paid to participant)

Loss of: One hand or foot, or
Sight in one eye $10,000
(paid to participant)

If the participant suffers more than one loss in an accident, payment will be made only for the one loss for which the largest amount is payable.

Loss of hand or foot means complete and permanent severance at or above the wrist or ankle; loss of sight means total and irrecoverable loss of sight.

Exclusions

The accidental death and dismemberment benefit is not payable for losses from:

- intentionally self-inflicted injury (while sane or insane),
- suicide (while sane or insane),

- war or any act of war, or service in the armed forces of any country engaged in war or police duty,

- participation in, or as the consequence of having participated in the commission of an assault or a felony by the participant,

- travel in any kind of an aircraft as a pilot or crewman, or in any kind of an aircraft owned, operated, or leased by or on behalf of you,

- disease or bodily or mental infirmity, or medical or surgical treatment thereof, ptomaine or bacterial infections (except infections occurring through an accidental cut or wound),

- voluntary use or consumption of any poison, chemical compound, or drug, unless used or consumed in accordance with the directions of a Physician.

HOW TO FILE A CLAIM FOR DEATH OR DISMEMBERMENT BENEFITS

The Administrative Office should be notified immediately of a claim. The necessary forms will be sent to the claimant so that payment of the claim may be made promptly.

All death certificates and correspondence should be submitted to the Administrative Office at:

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

CHAPTER 5 - COORDINATION OF BENEFITS (COB)

The Coordination of Benefits provisions described in this Chapter apply only to the Fee-For-Service PPO Medical option. If you are enrolled in an HMO or EPO, you should refer to the benefit booklet (Evidence of Coverage) issued by the HMO or EPO for information on Coordination of Benefits.

In this Chapter you'll find:

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

For purposes of this Coordination of Benefits (COB) provision, "group plan" means (1) group, blanket or franchise insurance, (2) service plan contracts, group practice, individual practice and other prepayment coverage, (3) labor-management trustee plans, union welfare plans or employee benefit organization plans, or (4) Medicare, and "Plan" means the Fee-For-Service PPO Medical option under Plan A.

CARVE-OUT COB METHOD

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

Benefits payable by the other group plan include benefits that would have been payable had claim been duly made for them or, in the case of an HMO or other managed health care plan, the benefits that would have been available had the individual followed the plan's coverage rules for obtaining covered services. In the event an individual does not follow his other plan's rules for obtaining covered services and such plan is primary to the Plan in accordance with the "Rules for Determining Primary Plan" that begin on page 68, then the Plan will not pay more than the member co-payments or co-insurance that would have applied under the other plan for the services rendered had the individual followed the other plan's coverage rules.

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

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

Following is an example of how benefits under the Plan are determined when the Plan is secondary to another group plan.

Example:

Spouse's fee-for-service plan is primary
This Plan is secondary for the spouse
Assuming all deductibles are met –

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

RULES FOR DETERMINING PRIMARY PLAN

A. Basic Rules

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

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

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

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

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

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

- a plan covering the claimant as a dependent child of a parent with financial responsibility for the child's health care expenses by virtue of a court decree is primary; however, if the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the "birthday rule" previously outlined,

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

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

  1) a plan covering the parent with legal custody,

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

  3) a plan covering the parent without legal custody.

B. Special Rules for Medicare Coverage

When the other plan, which covers the claimant is Medicare, the Plan is secondary to Medicare unless the applicable provisions of federal law specifically require otherwise. Refer to the Medicare discussion in Chapter 7 for details on when the Plan is secondary to Medicare.

C. Special Rules for COBRA Extension

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

D. Coordination with Other Government Programs

1. Medicaid: If a participant is covered by both the Plan and Medicaid or a State Children's Health Insurance Program (CHIP), the Plan pays first and Medicaid or CHIP pays second.

2. TRICARE: If a dependent is covered by both the Plan and the TRICARE Program (formerly CHAMPUS) that provides health care services to dependents of active Uniformed Services personnel, the Plan pays first and TRICARE pays second. For a participant called to active duty for more than 30 days who is covered by both TRICARE and the Plan, TRICARE is primary and the Plan is secondary for active members of the Uniformed Services only.

   If a participant under the Plan receives services in a military medical hospital or facility on account of a military service-related illness or injury, benefits are not payable by the

Plan.

If a participant under the Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan. If a participant under the Plan receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is **not** a military service-related illness or injury, benefits are payable by the Plan to the extent those services are Covered Services under the Plan.

3. If a participant under the Plan is covered for benefits by both the Plan and any motor vehicle coverage, including but not limited to no-fault, uninsured motorist, underinsured motorist, or personal injury protection rider to a motor vehicle liability policy, that motor vehicle coverage pays first, and the Plan pays second.

E. Final Determination

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

F. Dual Coverage under the Plan

If you and your spouse are both covered as participants under the Plan, the Plan will be both the primary and secondary provider for you and your spouse and eligible dependent children. If a child is covered as a participant and as a dependent under the Plan, the Plan will be both the primary and secondary provider for the child. In dual coverage situations, the Plan, as primary provider, will pay regular Plan benefits. As secondary provider the Plan will also pay regular Plan benefits but in an amount not to exceed the difference between 100% of Allowable Charges for Covered Services and what the Plan paid as primary provider. In other words, the Plan will never pay more than 100% of Allowable Charges as both primary and secondary payer combined.

G. Important Note for Medicare Beneficiaries

If Medicare would be primary for your claims, but you have not enrolled in Medicare Part A and Part B or you have not submitted a claim to Medicare, the Plan will estimate what Medicare would have paid had you enrolled and/or submitted a claim to Medicare, and will deduct that amount when it calculates your benefit payment from the Plan.

FILING CLAIMS WHEN YOU ARE COVERED UNDER MORE THAN ONE PLAN

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

FACILITY OF PAYMENT

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

CHAPTER 6 - MEDICARE

In this Chapter you'll find:

- **General information about Medicare**
- **How to enroll in Medicare**
- **How Medicare affects the Fee-For-Service PPO Medical option**

GENERAL MEDICARE INFORMATION

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

HOW TO ENROLL IN MEDICARE

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

HOW MEDICARE ELIGIBILITY AFFECTS THE FEE-FOR-SERVICE PPO MEDICAL OPTION

If the Fee-For-Service PPO Medical option is secondary to Medicare, that option will not pay any benefits that could have been available to you under Medicare Part A and Part B had you enrolled. The Fee-For-Service PPO Medical option is secondary to Medicare under the following circumstances:

- Where a participant has reached 65 years of age, is eligible for Medicare Part A, and is employed by an employer who does not have 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year and the preceding calendar year, Medicare will be the primary payer and the Fee-For-Service PPO Medical option will provide secondary coverage.

- If, while actively employed, a participant under the Plan becomes entitled to Medicare because of end-stage renal disease (ESRD), the Fee-For-Service PPO Medical option pays first and Medicare pays second for 30 months starting the **earlier** of the month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare will be the primary payer and the option will provide secondary coverage.

When Medicare would have been primary for you but you have not enrolled in or submitted your claims to Medicare, the Plan will estimate what Medicare would have paid had you enrolled and submitted your claims and will deduct that amount when it calculates your benefit payment from the Fee-For-Service PPO Medical option.

The following special rules also apply when you are enrolled in Medicare and Medicare is primary for you:

- **When Covered by the Fee-For-Service PPO Medical option and the Individual Also Enters into a Medicare Private Contract:** By law a Medicare participant is entitled to enter into a Medicare private contract with certain health care practitioners under which he or she agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that health care practitioner. If a Medicare participant enters into such a contract, the Fee-For-Service PPO Medical option will pay benefits for health care services and/or supplies the Medicare participant receives pursuant to it, but those benefits will be subject to all of the option's terms and provisions and will pay 20% of the Allowable Charges for Covered Services after the deductible is satisfied, and the Medicare participant is responsible for the rest.

- **When Covered by the Fee-For-Service PPO Medical option and also by a Medicare Advantage Program (formerly called Medicare + Choice or Part C) and/or a Medicare Part D Plan (prescription drug coverage):** If a participant is covered by both the Fee-for-Service PPO Medical option and a Medicare Advantage program, and obtains medical services or supplies in compliance with the rules of that program, including, without limitation, obtaining all services In-Network when the Medicare Advantage program requires it, the option will reimburse all applicable co-payments and will pay the same benefits provided for active employees less any amounts paid by the Medicare Advantage program.

  Also, if a participant does not comply with the rules of their Medicare Advantage program, including without limitation, approved referral, precertification/pre-authorization, case management, or utilization of in-network provider requirements, the Fee-For-Service PPO Medical option will NOT provide any health care services or supplies or pay any benefits for any services or supplies that the individual receives.

CHAPTER 7 – GENERAL LIMITATIONS AND EXCLUSIONS

The limitations and exclusions listed in this Chapter apply to the Fee-For-Service PPO Medical option, including the Prescription Drug Benefits described in this booklet. If you are enrolled in an HMO or EPO, you should refer to the benefit booklet (Evidence of Coverage) issued by the HMO or EPO for information on limitations and exclusions.

In this Chapter you'll find:

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

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

No payment will be made for:

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

2. any bodily injury or sickness for which the patient is not under the care of a provider who is determined by the Plan to be a Recognized Provider; or care or treatment provided by a Recognized Provider to the extent such care or treatment is outside the scope of the Recognized Provider's license or certification or the care or treatment is not a covered service under the Fee-For-Service PPO Medical option;

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

4. any services or supplies:

   (a) for which no charge is made, or

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

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

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

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

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

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

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

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

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

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

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

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

underlying health factor;

12. fees to complete claim forms;

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

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

Expenses Incurred Outside the United States and Its Territories

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

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

CHAPTER 8 – OTHER IMPORTANT INFORMATION

This Chapter includes:

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

PRIVACY OF HEALTH INFORMATION

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

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

HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NON-DISCRIMINATION IN HEALTH CARE

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

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

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

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

CLAIMS REVIEW PROCEDURES

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

- eligibility under any of the Plan's benefit options,
- the Fee-For-Service PPO Medical option including Prescription Drug Benefits provided to individuals covered under that option, and
- Death Benefits and Accidental Death and Dismemberment benefits.

Different claims review procedures apply to the HMO and EPO medical options, dental options, and vision care benefits. For those procedures, please refer to the Evidence of Coverage/disclosure booklet issued by the applicable insurance organization.

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

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

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

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

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

Timing of Initial Claims Decisions

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

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

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

An initial determination on **post-service Claims** will be made by the Plan or its authorized designee within 30 calendar days from receipt of the Claim (45 calendar days if additional information is needed and the Plan informs the claimant of the extension within 30 days from receipt of the Claim). If additional information is needed from the claimant, the claimant will

have 45 days to respond. The deadline for the initial determination will then be suspended for 45 days or until the information is received. The claimant will be notified of the decision within 15 days after the additional information is received or the end of the 45-day response period whichever is earlier.

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

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

Denied Claims (Adverse Benefit Determinations)

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

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

Written notices will include the following information:

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

- a description of any additional material or information necessary if you want a further review of the claim and an explanation of why the material or information is necessary;

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

- a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse appeal determination (civil actions must be brought within one year of a final and binding decision of the Board of Trustees on your claim or appeal; see page 93);

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

- if the determination was based on not being Medically Necessary or the treatment's being Experimental or investigational or other similar exclusion, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge; and
- disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

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

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

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

Internal Appeal of an Adverse Benefit Determination

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

A review will then be made by the Eligibility Committee, which is a Committee of the Board of

Trustees of the Plan whose members are appointed by the Board. The Eligibility Committee will independently consider all comments, documents, records, and other information submitted by you or your authorized representative relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

You will be advised in writing of the decision of the Eligibility Committee. This will include a written explanation giving detailed reasons for any denial, specific reference to the Plan provisions on which the denial is based, a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary, and a description of the Plan's review procedures and applicable time limits, including a statement of your right to bring a civil action under Section 502(a) of ERISA following completion of the Plan's two-level appeals process. (Civil actions must be brought within one year of a final and binding decision of the Board of Trustees on your claim or appeal; see page 93.)

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

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

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

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

The Appeals Committee will independently consider the appeal using the written application presented by you, and/or by hearing the appeal of the individual who has requested a personal appearance at the Appeals Committee hearing. You will be advised in writing of the decision of the Appeals Committee. This will include specific reasons and references to pertinent Plan provisions or documents on which the decision is based; a statement of your rights to receive,

upon request and free of charge, reasonable access to, and copies, of all documents, records, and other information relevant to your Claim; and a statement of your right to bring a civil action under Section 502(a) of ERISA. (Civil actions must be brought within one year of a final and binding decision of the Board of Trustees on your claim or appeal; see page 93.)

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

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

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

Elimination of Conflict of Interest

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

Review Process

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

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

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

- Was relied on in making the benefit determination;
- Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether it was relied upon in making the benefit determination;
- Demonstrates compliance with the Plan's administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing Plan documents and that, where appropriate, Plan provisions have been

applied consistently with respect to similarly situated claimants; or

- Constitutes a statement of policy or guidance with respect to the Plan concerning any denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

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

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

Review of all appeals, other than appeals concerning claims for death benefits or AD&D benefits, will afford no deference to the initial Adverse Benefit Determination (or to the previous appeal decision, in the case of a second level appeal).

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

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

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

Time Frames for Notice of Decision on Appeal

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

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

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

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

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

- **Death benefits or accidental death and dismemberment claims:** Decisions will ordinarily be made within **60 days** of receipt of appeal by the Administrative Office. The period for making a decision may be extended by up to **60 days**, provided the Administrative Office notifies you, prior to the expiration of the first 60 days, of the circumstances requiring the extension and the date as of which the Eligibility Committee expects to render a decision.

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

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

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

- A discussion of the decision;

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

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

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

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

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

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

- If the original Adverse Benefit Determination is upheld, in whole or in part, the notice will state whether an internal rule, guideline, protocol, or other similar criterion was relied upon in making any adverse determination, and if so, either the specific rule, guideline, protocol, or other similar criterion, or a statement that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request; and

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

The decision of the Appeals Committee is the final internal Adverse Benefit Determination and is binding on the Plan. Following a final internal Adverse Benefit Determination, if the claimant continues to believe that the decision is contrary to the terms of the Plan, he or she has the right to request an external review or bring a civil action challenging the decision under section 502(a) of ERISA, 29 U.S.C. §1132(a). However, no legal or equitable action for benefits under the Plan may be brought unless and until the final internal Adverse Benefit Determination has been completed and a decision rendered. Any suit or claim must be filed within one year of the decision of the Appeals Committee (see page 93).

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

External Review of Denied Claims

Time Frame and Procedures for Standard External Review

External Review Procedures: Your Obligations. You may request an external review, by an

Independent Review Organization ("IRO"), only in the situation where your appeal of a health care claim, whether urgent, concurrent, pre-service, or post-service claim, is denied and it fits within the following parameters:

- The denial involves medical judgment, including but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, an adverse determination related to coverage of routine costs in a clinical trial, or a determination that a treatment is experimental or investigational. The IRO will determine whether a denial involves a medical judgment; and/or

- The denial is due to a Rescission of coverage (retroactive elimination of coverage), regardless of whether the Rescission has any effect on any particular benefit at that time.

External review is not available for any other types of denials, including death or AD&D benefits, dental or vision coverage, or if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan.

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

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

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

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

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

The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- The claimant's medical records;
- The attending health care professional's recommendation;
- Reports from the appropriate health care professionals and other documents submitted by the Plan, claimant, or the claimant's treating Provider;
- The terms of the claimant's plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
- The opinion of the IRO's clinical review or reviewers to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

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

The assigned IRO's decision notice will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
- The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or the claimant;
- A statement that judicial review may be available to the claimant; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance.

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

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

Time Frame and Procedures for Expedited External Review

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

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

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

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

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents submitted. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

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

Appeals of Adverse Benefit Determinations Made by Third Party Vendors

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

under the agreement between the Plan and the third party vendor, which decision shall comply with all applicable law.

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

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

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

There is no second-level appeal to the Plan's Appeals Committee for claims regarding the following insured benefits: HMO, EPO, dental, and vision. For these insured benefits, appeals will be handled by the carrier according to the procedures specified in the carrier's Disclosure Form/Evidence of Coverage booklets, copies of which may be obtained from the Plan's website, www.sheetmetalsam.org.

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

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

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

THIRD PARTY LIABILITY

If you receive a recovery from any source whatsoever, including, but not limited to, first party

uninsured motorist coverage and/or third party liability coverage (auto accident, Worker's Compensation, or other), the Plan is entitled to recover the amount of benefits paid under the Plan.

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

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

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

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

Obligation to Repay the Plan Out of Third Party Recoveries

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

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

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

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

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

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

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

Upon acceptance of the relevant eligibility status, including by enrollment in the Plan, and as a condition thereto, the Payee agrees to the repayment right of the Plan as described above. In addition, if Plan counsel so requests, the Payee will be required to sign supplemental contractual documents satisfactory to the Plan further obligating the Payee to satisfy the Plan's reimbursement rights as described above and in such further specificity as such documents shall provide. If the Payee fails to sign the lien agreement or these documents, or otherwise materially fails to fulfill the reimbursement obligation described in the first sentence of this paragraph, the eligibility status of the Payee and any other individual whose status as such is conferred by, or derived from, the Payee, shall be terminated upon written notice from the Plan, and no reimbursements by or on behalf of such Payee shall be paid by the Plan thereafter respecting such former eligible individual pending satisfaction of the Plan's repayment right as described in this paragraph.

DISCLAIMERS

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

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

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

provisions contained in this booklet and inserts shall prevail.

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

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

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

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

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

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

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

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

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

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

GENERAL PLAN PROVISIONS

Payment of Benefits

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

Assignment of Benefits

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

Payment of Benefits under Special Circumstances

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

Physical Examination and Autopsy

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

Discretionary Authority

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

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

Worker's Compensation Not Affected

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

Trust Agreement

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

Changes in Eligibility Status and Coverage

How it Affects Deductibles

Any **medical deductibles** under the options available under Plan A and the options available under the Retiree Plan **are separate** deductibles. In the event coverage changes either from Plan A to the Retiree Plan or from the Retiree Plan to Plan A, any medical deductible(s) under the plan to which you are transferring **must be met** before benefits become payable.

The **medical deductibles** under the options provided under Plan A and Plan B **are not separate** deductibles. In the event coverage changes either from Plan A to Plan B or from Plan B to Plan A, any amounts applied to your medical deductible(s) under the option from which you are transferring **will also be applied** to the medical deductible(s) under the option to which you are transferring.

In the event your eligibility status changes from a participant to a dependent or from a dependent to a participant, any amounts applied to the **medical deductible and dental deductible** prior to the eligibility status change **will also be applied** after the eligibility status change.

Right to Receive and Release Necessary Information

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

Right of Recovery

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

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

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

Delinquent Owner-Participants

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

Alternative Treatment

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

Headings Do Not Modify Plan Provisions

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

Pronouns

All pronouns and any variations thereof refer to and include the masculine, feminine, neuter,

singular, or plural, as the context may require.

YOUR RIGHTS UNDER ERISA

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

Receive Information about Your Plan and Benefits

You have the right to:

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

- Obtain, upon written request to the Administrative Office, copies of documents governing the operation of the Plan. These include insurance contracts, Collective Bargaining Agreements, copies of the latest annual report (Form 5500 Series), current Plan Document with amendments and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review Chapter 1 of this SPD booklet, or HMO booklets, for the rules governing your COBRA continuation coverage rights (and in the case of HMO coverage, Cal-COBRA rights).

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

Assistance with Your Questions

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

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

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

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

PLAN FACTS

- **NAME OF PLAN:** The Plan is known as the Sheet Metal Workers' Health Plan of Southern California, Arizona and Nevada. The benefits described in this booklet cover active participants and their dependents under Plan A.

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

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

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

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

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

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

  Legal process may also be served on a Plan Trustee.

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

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

- **TYPE OF PLAN:** Plan A is maintained for the purpose of providing Death, Dismemberment, Hospital, Medical, Prescription Drug, Dental, and Vision Care benefits in the event of sickness, injury, or death.

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

- **IDENTITY OF PROVIDER OF SERVICES OR BENEFITS:** The death, dismemberment, fee-for-service medical, and prescription drug benefits described in this booklet are provided directly from the Plan itself. The Plan has an administrative service agreement with Express Scripts for its prescription drug program, Beat It for its substance abuse utilization program, Anthem Blue Cross for its utilization review program, case management and PPO programs. None of these organizations insure or guarantee benefits. Optional HMO and EPO medical programs are provided by Kaiser, Health Net, Health Plan of Nevada, Hometown Health, and United HealthCare. Delta Dental provides PPO and DMO dental coverage. Anthem Blue Cross provides PPO vision care coverage. Premiums are paid to the HMOs/EPO and dental/vision insurance companies on behalf of participants who have elected coverage under these plans, in turn, those organizations fully insure the benefits provided by them.

  Kaiser, Health Net, United HealthCare/PacifiCare, Health Plan of Nevada, Hometown Health, Delta Dental, and Anthem Blue Cross (vision) pay claims and handle claim appeals related to their programs of benefits. These organizations will supply you, upon written request, written materials concerning the nature of services provided, conditions pertaining to eligibility to receive such services (other than general conditions pertaining to eligibility for participation in the Plan) and circumstances under which such services may be denied, the procedures to be followed in obtaining such services, and the procedures available for the review of claims for services which are denied in whole or in part. Requests for such materials may be addressed to the Plan Administrator at the address given in "Plan Sponsor and Administrator" above.

  The names and addresses of the insurance companies and service organizations are:

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

Anthem Blue View Vision
P.O. Box 8504
Mason, OH 45040-7111
(866)-723-0515

Beat It!
2540 North 1st, Suite 303
San Jose, CA 95130
(800) 828-3939

Delta Dental
100 First Street
San Francisco, CA 94120
(888) 335-8227

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

Health Net
21600 Oxnard Street
Woodland Hills, CA 91367
(800) 522-0088

Health Plan of Nevada (HPN)
3320 West Sahara Avenue
Suite 300
Las Vegas, NV 89114
(800) 777-1840

Hometown Health (HHP)
400 South Wells Avenue
Reno, NV 89502
(702) 325-3000 or (800) 336-0123

Kaiser
493 East Walnut
Walnut Center
Pasadena, CA 91188
(800) 464-4000

United HealthCare - Arizona
410 North 44th Street
Phoenix, AZ 85072
(800) 278-5802

United HealthCare - California
5856 Corporate Avenue
Cypress, CA 90630
(800) 624-8822

United HealthCare - Nevada
700 East Warm Springs Road
Las Vegas, NV 89119
(800) 347-8600

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

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

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

- **CLAIMS FILING AND CLAIMS APPEAL PROCEDURE** is described in Chapters 1 and 8 of this booklet.

This booklet contains a summary in English of your plan rights and benefits under the Sheet Metal Workers' Health Plan of Southern California, Arizona and Nevada. If you have difficulty

understanding any part of this booklet, contact the Administrative Office at 111 North Sepulveda Blvd., Suite 100, Manhattan Beach, California 90266. The office hours are from 7 a.m. to 5 p.m., Monday through Friday. You may also call the Administrative Office at (800) 947-4338 for assistance.

GLOSSARY OF TERMS USED IN THIS BOOKLET

Listed below are definitions of some of the terms used in this booklet. **Please be sure that each provider you intend to use is legally qualified to perform the desired care and that the provider is a Recognized Provider and an Eligible Provider as defined herein.**

- "**Allowable Charge(s)**" means the dollar amount used by the Plan when calculating a benefit payment under the Plan as follows:

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

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

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

  In accordance with federal law, with respect to Emergency services performed in a Non-PPO emergency room (ER), the Plan's allowance for ER visit facility fees is to pay according to the billed charges, and the allowance for ER professional fees is the greater of:
  a) the negotiated amount for PPO providers (the median amount if more than 1 amount to PPO providers), or
  b) 100% of the Plan's usual payment (Allowable Charge) formula (reduced for cost-sharing), or
  c) when such database is available, the amount that Medicare Parts A or B would pay (reduced for cost sharing).

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

- "**Ambulatory Center/Surgicenter**" means a distinct entity which primarily operates for the purpose of providing outpatient surgical services to patients and which meets all of the following requirements:

  - is operated under the supervision of a Physician,
  - has at least one operating room available for surgery,

- has an anesthesiologist or another Physician qualified in resuscitative techniques present or immediately available each day surgery is performed until all patients who have undergone surgery for that day are discharged,
- maintains a clinical record for each patient,
- has, for patients requiring hospitalization, a written transfer agreement with a Hospital within the proximity of the ambulatory center or Surgicenter or permits surgery only by Physicians who have admitting privileges and similar surgical privileges at a Hospital within the proximity of the ambulatory center, and
- is operating lawfully within the state it is located.

➢ "**Birthing Center**" means a distinct entity which exclusively operates for the purpose of providing prenatal care, delivery and immediate post-partum care on an outpatient basis for patients with low-risk pregnancies and which meets all of the following requirements:

- is operated under the supervision of a Physician,
- provides skilled nursing care in the delivery and recovery rooms under the direction of a Registered Nurse,
- has a written agreement with a Hospital located in the same proximity of the birthing center for immediate transfer of patients in case of Emergency,
- has an anesthesiologist or other Physician qualified in resuscitative techniques present or immediately available each day surgery is performed until all patients who have undergone surgery for that day have been discharged, and
- is operating lawfully within the state it is located.

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

➢ "**Claim**" means a request for a plan benefit made by a claimant (or the claimant's authorized representative) in accordance with the Plan's claims procedures described in Chapters 2 and 8. To be considered a claim, the following elements must exist:

- written or electronically submitted communication to the Administrative Office or Utilization Review Firm (oral communication is acceptable for urgent care claims and pre-authorization requests),
- the communication must name a specific claimant,
- the communication must name a specific medical condition or symptom, and
- the communication must name a specific treatment, service or product for which approval or payment is requested.

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

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

surgical treatment intended to restore or improve physical appearance, as determined by the Board of Trustees or its delegate.

- "**Covered Service(s)**" means those services or supplies which are medically necessary and reasonable and customary for the diagnosis or treatment of the illness or injury being treated for which benefits are provided under the Plan, as determined in the sole and absolute discretion of the Board of Trustees. The fact that a procedure or level of care is prescribed by an Eligible Provider does not mean that it is medically necessary or that it is covered by the Plan. Services that are not medically necessary and reasonable and customary shall include, but are not limited to, the following:
  - procedures which are of unproven medical value or of questionable current therapeutic usefulness,
  - procedures which tend to be redundant when performed in combination with other procedures,
  - diagnostic procedures which are unlikely to provide an Eligible Provider with additional information when they are used repeatedly,
  - procedures which are not prescribed by an Eligible Provider or which are not documented at the time services are rendered in the patient's medical file,
  - procedures or hospitalization which can be performed with equal efficiency at a lower level of care, or
  - procedures or confinement, which are considered by the Plan to be Custodial Care, Cosmetic Surgery or Treatment or Experimental.

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

- "**Dentist**" means a dentist licensed to practice dentistry in the state in which he/she renders treatment.

- "**DMO**" means Dental Maintenance Organization.

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

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

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

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

  When making a determination under this definition, the Board of Trustees or its delegate shall refer to reliable evidence, which may be derived, without limitation, from one or more of the following sources:
  - published, authoritative peer-reviewed medical and scientific literature regarding the procedure at issue as applied to the injury or illness at issue,
  - publications and evaluations from national medical associations, such as the American Medical Association or specialty medical associations,
  - regulations and other official guidelines or publications issued by the U.S. Food and Drug Administration (FDA) or Department of Health and Human Services, and
  - written protocols and consent forms used by the treating facility or by another facility administering substantially the same drug, device or medical treatment.

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

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

  The fact that a Physician or other medical professional or expert may prescribe, order,

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

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

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

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

- "**Hospice Care**" means a method of caring for the terminally ill that helps those individuals continue their lives with as little disruption as possible. In order to be considered terminally ill, the individual must have a medical prognosis of six months or less to live. The care may include the following services and supplies:
  - nursing care provided under the supervision of a Registered Nurse,
  - physical therapy, occupational therapy and speech pathology,
  - medical social services under the direction of a Physician,
  - services of a home health aide who has successfully completed a training program approved by Medicare,
  - homemaker services,
  - medical supplies and the use of medical appliances,
  - Physicians' services,
  - short-term inpatient care (including procedures necessary for pain control and acute and chronic symptom management) in an appropriate inpatient facility such as a participating Hospital or nursing home that meets hospice qualification requirements. However, respite care may be provided only on an intermittent, non-routine and occasional basis and may not be provided consecutively over longer than five days.

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

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

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

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

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

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

- "**Nurse-Midwife**" means a Registered Nurse who has gained the special knowledge and skills of child delivery in an educational program accredited by the American College of Nurse-Midwives and who is licensed in the State by the Board of Registered Nursing as a Nurse-Midwife.

- "**Participant**" (**or "participant"**) means an active sheet metal worker or other individual who meets the eligibility requirements for coverage under Plan A as an employee.

- "**Participating Pharmacy**" is a pharmacy that has a written agreement to provide pharmacy

services to Plan participants at specified costs.

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

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

- "**Plan A**" means the health care options and eligibility rules designated as Plan A by the Plan that apply to active sheet metal workers specified as Plan A participants under applicable collective bargaining agreements.

- "**Plan B**" means the health care options and eligibility rules designated as Plan B by the Plan that apply to active sheet metal workers specified as Plan B participants under applicable collective bargaining agreements.

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

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

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

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

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

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

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

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

- "**Sheet Metal Industry**" means all work or services of the kind performed by any Contributing Employer to the Sheet Metal Workers' Pension Plan of Southern California, Arizona, and Nevada, which relates in any way to any work performed by employees covered by the Pension Plan. For example, in addition to manufacturing, fabrication, service, design and installation of products or goods by Contributing Employers, the Sheet Metal Industry includes, but is not limited to, the following functions:
  - an ownership interest in, or any work or consulting for, any establishment which manufacturers, fabricates, services, designs, installs, repairs or sells any items of the type so handled by any Contributing Employer; whether or not the establishment is incorporated and whether or not it contributes to the Pension Plan. If your spouse has any such connection with the Sheet Metal Industry, you are deemed to also have compensation or profit from the Industry. If your spouse has an ownership interest in a sheet metal employer, you are deemed to also have an ownership interest,
  - acting in a sales, consulting, estimating or design capacity relating to any items of the types manufactured, fabricated, serviced, designed, installed, repaired, sold, etc. by any Contributing Employer, or
  - any other work relating in any way to the manufacture, fabrication, service, design, installation, repair or sale of any item of the type handled by any Contributing Employer.

- "**Uniformed Services**" means the United States Armed Services (including the Coast Guard), the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

- "**Utilization Review Firm**" means an organization under contract with the Plan to perform health care utilization review services.

- "**Visit**" means a personal interview between a patient and an Eligible Provider. It does not include telephone calls, internet contact, or any other situations where the patient is not personally examined by the Eligible Provider.

- "**You**" (**or "you"**) means an active sheet metal worker, dependent, or other individual who meets the eligibility requirements for coverage under Plan A.

MEMBERS OF THE BOARD OF TRUSTEES

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

The Trustees of the Plan (as of the printing of this booklet) are listed on the next two pages.

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