SHEET METAL WORKERS
LOCAL 104
HEALTH CARE PLAN

SUMMARY PLAN DESCRIPTION

January 2021
Including Amendments 1 and 2

TELEPHONE DIRECTORY

Provider	Website	Telephone No.
Beat It! (Substance Abuse Provider)	www.beatiteap.com	(800) 828-3939
Blue Shield of California (PPO Network and Utilization Review)	www.blueshieldca.com	(800) 541-6652
WellDyneRx (Prescription Drug Provider)	www.WellDyneRx.com	(888) 479-2000
Kaiser Permanente (Membership Services)	www.kp.org	(800) 464-4000
Medicare (Social Security Administration)	www.medicare.gov	(800) 772-1213
Delta Dental (Dental Network)	www.deltadentalins.com	(800) 765-6003
VSP (Vision Network)	www.vsp.com	800-877-7195
Trust Fund Office	www.sheet104fringe.org	(800) 548-1771; or (925) 208-9994

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Dear Plan Member, Spouse and Dependent:

This booklet summarizes the benefits offered by the Sheet Metal Workers Local 104 Health Care Plan. Please destroy any printed material dated prior to January 1, 2021, as it may be misleading or incorrect.

You and your family members should become familiar with the eligibility rules explained in this booklet. Eligible employees and dependents may choose medical coverage provided directly by the Plan or Kaiser Permanente. You may change the medical and/or dental program covering yourself and your eligible dependents only once in any 12-month period. The Plan also provides dental care, vision care, alcohol and substance abuse benefits, death benefits and accidental death and dismemberment benefits.

The Sheet Metal Workers Local 104 Supplemental Unemployment Benefit and Supplemental Health Care Plan was merged into the Sheet Metal Workers Local 104 Health Care Plan on July 1, 2001. This booklet contains a summary of these benefits.

Except for death or accidental death and dismemberment benefits, Plan benefits are payable only for non-occupational illnesses and injuries. Employment-related injuries and illnesses are excluded from coverage under this Plan as these claims are generally paid through Workers' Compensation programs.

The Trustees of the Plan hope that these benefits will protect you and your dependents if any of you suffer illness or injury. By taking advantage of the preferred provider discounts and following the rules requiring pre-certification of hospital stays and other cost containment features, you will be eligible for maximum benefits. At the same time, you will help the Plan to provide benefits in the most cost-effective way possible.

Only the full Board of Trustees is authorized to interpret the Plan. The Board has discretion to decide all questions about the Plan, including questions about your eligibility for benefits and the amount of any benefits payable to you. The Board also has discretion to make any factual determinations concerning your claim. No individual Trustee, employer or union representative has authority to interpret this Plan on behalf of the Board or to act as an agent of the Board.

The Board has authorized the Trust Fund Office to respond in writing to your written questions. If you have a question about your benefits, you should write to the Trust Fund Office for a definitive answer. As a courtesy to you, the Trust Fund Office may also respond informally to oral questions. However, the oral information and answers are not binding upon the Board of Trustees and cannot be relied on in any dispute concerning your benefits.

Plan rules and benefits may change from time to time. If this occurs, you will receive a written notice explaining the change. Please be sure to read all Plan communications and keep them with your booklet.

Be sure to inform the administrative office in writing if you change your address.

THE BOARD OF TRUSTEES

CLAIMS AND APPEALS

If your claim for benefits is denied you may appeal to the Board of Trustees. If your appeal is denied by the Board of Trustees, you may file a civil action under ERISA Section 502(a). No lawsuit may be filed without exhausting the Plan's review procedure. In any such lawsuit, the decision of the Board of Trustees will be subject to judicial review only for abuse of discretion. No legal action may be commenced or maintained against the Trust or Plan more than two (2) years after the claim has been denied.

See the Plan's complete Claims and Appeals Procedure starting on Page 94 of this booklet.

HELP PREVENT WASTE AND FRAUD

Every year billions of health care dollars are wasted because of fraudulent claims. Fraud may consist of false statements on bills or claim forms, or the omission of important information which would cause the claim to be denied.

You and your family can help prevent fraud. Do not give details about your health coverage to anyone except your authorized health care providers. Do not sign blank claim forms. Inform the Plan if outsiders attempt to obtain billing information or claim forms from you. Carefully review your bills and the Plan's written explanation of each benefit payment, and immediately report any discrepancies. Respond promptly if the Plan administrator requests your help to verify that a claim is valid.

Your Plan takes fraud very seriously. All claims are checked to be sure the patient is eligible and the treatment was received. The Trustees require a full refund of any benefit payment obtained by fraud, with interest and legal costs. Any incident involving fraud also may be referred to the authorities for criminal prosecution. Attempting to defraud a health plan is a crime under both federal and state laws, even if the fraud is detected and the plan is not actually harmed. If you observe any activities by health care providers or others which might indicate fraud, please alert the Trust Fund Office in writing immediately. The Plan will investigate the matter and take whatever action is necessary. If you wish, your report will be entirely confidential.

LOSS OF ELIGIBILITY FOR MAKING FALSE STATEMENTS OR FAILING TO REPAY ANY OVERPAYMENT

If the Trustees determine that you submitted false information in connection with a benefit claim, no benefits will be payable to you for the longer of (a) twelve (12) months during which you otherwise would have been covered or (b) the period of time necessary to recover the amount of any erroneous benefits or premium payments made in reliance upon the false statement.

Concealment or omission of material information, such as a divorce or a child's loss of student eligibility or accurate marital status, is considered a false statement covered by this

rule. A claim of the lack of knowledge is insufficient and the concealment or omission of material information will still be considered a false statement.

If you fail to repay the Plan for an overpayment of benefits, your eligibility may be suspended immediately. If your eligibility is suspended under this rule, you will not be permitted to draw upon your Hour Bank for coverage until the suspension period is ended. You will not be eligible for subsidized self-pay coverage.

In addition to suspending benefit eligibility, the Trustees may report any false statement to the authorities for criminal prosecution under federal and/or state laws. If you are convicted, you could be required to pay a $5,000 penalty and serve up to 5 years in prison for *each* false statement or omission.

PLAN PROVISIONS, RULES AND REGULATIONS ARE SUBJECT TO CHANGE

All Plan benefits and eligibility rules are subject to the terms of the Trust Agreement and to the rules and regulations adopted from time to time by the Trustees. Where benefits are provided by an organization which contracts with the Trust Fund, those benefits are subject to the terms and conditions of the contract between the provider and the Trust Fund.

The Plan description in this booklet is intended to summarize the provisions of the coverage at the time the booklet was prepared.

The Plan complies with all applicable federal laws, as well as state laws not preempted by federal law. To the extent that any Plan provision violates such laws, that Plan provision shall be deemed void, and the remaining Plan provisions shall continue in full force and effect.

NOTIFICATION OF ADDRESS CHANGE

From time to time, the Trust Fund Office may wish to inform you of changes in the Plan, or obtain information related to your benefits under the Plan, or to inform you concerning administration of the Plan. **It is your responsibility to notify the Trust Fund Office, in writing, of any change in address.** Send any address changes to:

Sheet Metal Workers Local 104 Health Care Plan
P.O. Box 1917
San Ramon, CA 94583
www.sheet104fringe.org

Eligibility Rules

ELIGIBILITY RULES FOR ALL ACTIVE EMPLOYEES

Your eligibility for benefits depends on the continued and timely payment of employer contributions on your behalf. If your employer fails to make a contribution when it is due, your eligibility will cease, in accordance with Plan rules. Eligibility will be restored if and when the employer makes the required contribution.

If your employer pays only part of the required contribution, the money received will be applied to provide health coverage to employees in the following order:

1. Bargaining unit employees other than Owner/Members;
2. Owner/Members;
3. Non-bargaining unit employees other than Owner/Managers;
4. Owner/Managers.

BARGAINING UNIT EMPLOYEES

You are eligible for benefit coverage if you are employed under the jurisdiction of Sheet Metal Workers Local Union 104, District 1, as a member of the bargaining unit and if you are employed by an employer who agrees to contribute to the Plan on your behalf. For every hour that you work in Covered Employment for which your employer pays the required contribution, one hour will be credited to your Reserve Hour Bank up to the maximum number of hours.

Covered Employment is any of the following:

1. Employment under a written Collective Bargaining Agreement between Sheet Metal Workers Local 104, District 1, and an industry employer requiring contributions to this Plan on the employee's behalf.

2. Employment with a participating local union or apprenticeship office, or a related organization, for which the employer has agreed in writing, with the approval of the Trustees, to pay the required contribution.

Eligibility Rules

After you begin working in covered employment, contributions are paid to the Plan by your employer for each hour you work. However, your coverage under this Plan does not begin until you have accumulated enough hours to meet the Plan's initial eligibility requirements. Also, the minimum number of qualifying hours must be worked within the maximum time period allowed to accumulate these hours.

If you are actively employed within the bargaining unit represented by Sheet Metal Workers Local Union 104, District 1, or if you are actively employed in other Covered Employment described in Item Number 2 above, you must accumulate at least 120 hours in your Reserve Hour Bank within a 12-month period. Coverage begins on the first day of the second month following the month in which your Reserve Hour Bank has at least 120 hours.

1st Year Apprentices – Effective for work hours on or after January 1, 2021, a 1st year apprentice will be credited with 8 work hours towards his/her reserve hour bank for everyday he/she misses work to attend day-time classes, up to a maximum of six (6) weeks. This provision shall not apply to any class a 1st year apprentice has to repeat.

Continuing Eligibility

After becoming eligible for Plan coverage, you are required to have a minimum amount of hours in your Reserve Hour Bank to maintain eligibility. Continuing eligibility requires a minimum of 120 hours for 1 month of coverage.

FOR EXAMPLE: If you have 160 hours credited to your Reserve Hour Bank at the end of May, 120 hours (the minimum required hours) will be deducted to provide you with eligibility for Plan coverage for July. The remaining 40 hours will be carried forward, so that if you accumulate as few as 80 more hours in June, you will be eligible for August as well.

Reserve Hour Bank Maximum

The maximum number of months that can be credited to your Reserve Hour Bank at any time is 4 months, or 480 hours. For Residential Utility Workers and Maintenance Service Technicians, the maximum number of months that can be credited to your Reserve Hour Bank at any one time is one month, or 120 hours.

You may not draw upon your Reserve Hour Bank to maintain eligibility unless you are working or available for work in covered employment (signed on the out of work list at a local union affiliated with the Sheet Metal Workers International Association), disabled, retired or on vacation. The Plan may require satisfactory evidence of disability, retirement or vacation status as a condition of eligibility.

If your employer's contributions are delinquent for six months, no further hours will be credited to your Reserve Hour Bank for hours worked for that employer six months after the contributions first became delinquent. If you refuse the Union's demand to withdraw from your delinquent employer, you will forfeit your Reserve Hour Bank.

If you are covered as an owner/member, your reported hours in excess of 120 hours per month will be credited to your Reserve Hour Bank in the normal manner. However, you may not draw upon your reserve hours to provide eligibility until you cease operation as an owner/member, no longer maintain an active contractor's license, and sign the out-of-work list with the Union.

Re-Establishing Eligibility

If your Reserve Hour Bank falls below the minimum required hours, you can re-qualify if you restore the minimum required hours within 12 months after your eligibility terminates. Your Reserve Hour Bank will then be charged the required hours to provide you with eligibility for the second month following the month in which your Reserve Hour Bank reaches the required hours. If you do not bring your Reserve Hour Bank up to the required hours within 12 months after your eligibility terminates, any hours remaining in your Reserve Hour Bank will be forfeited and you will have to re-qualify in the same manner as a new employee.

Continued Eligibility Based on Reciprocal Contributions

Contributions you earn under another local union Collective Bargaining Agreement and paid to another health plan may be transferred to this Plan pursuant to a written reciprocity agreement. You may be required to complete a reciprocity request form and submit it to the plan in the area *you* are working. There is usually a delay of at least 30 days before the Plan receives reciprocity contributions from other health plans. This may result in an interruption in coverage and possibly a COBRA notice depending on the number of hours in your Reserve Hour Bank.

If you wish to stop contributions from being transferred from one union to the other, and have previously submitted a reciprocity agreement, you are required to submit a 'stop agreement' in order to terminate the reciprocity agreement.

NON-BARGAINING UNIT EMPLOYEES ELIGIBILITY RULES

Contributing employers signatory to a written Collective Bargaining Agreement with Sheet Metal Workers Local Union 104 may apply for health care coverage on behalf of themselves and their non-bargaining unit employees by signing a subscription agreement to contribute to the Plan on behalf of themselves and their non-bargaining unit employees. Other related groups including but not limited to employer associations are also eligible to participate in the Plan. Employees of contributing employers NOT eligible to participate in the Plan include employees who regularly work 16 1/2 hours per week or less or employees who are students and who are employed on a temporary basis during recognized school breaks or employees who are interns recognized by the Employer's Association and the Union. Special eligibility provisions may apply under the Subscription Agreement. To learn about any special provisions that may apply to you, call the Trust Fund Office.

When Coverage Begins For Non-Bargaining Unit Employees

As a non-bargaining unit employee, you will become eligible for Plan coverage after you have completed at least 17 hours per week of regular employment for the employer for at least two weeks during one calendar month, provided your employer has made all required contributions. Coverage becomes effective on the first day of the SECOND month following the month in which you work the qualifying number of hours. Your coverage continues as long as you work at least 17 hours for at least two weeks per calendar month and your employer continues to make all required contributions.

Continuation Coverage

Coverage for non-bargaining unit employees will terminate at the end of the last month for which contributions have been paid.

There is no right of self-payment except for COBRA continuation coverage. Please see more information regarding COBRA on page 21.

There is no reserve Hour Bank.

Retiree Coverage

There is no retiree health care coverage; however, an owner/manager who previously participated in the Plan as a bargaining unit employee may qualify for retiree coverage if, on the

last date of bargaining unit coverage, the individual had been covered for at least 64 of the 80 preceding calendar months. In addition, the Board of Trustees has discretion to extend retiree coverage to retired employees of related groups, under terms and conditions set by the Board. The cost of retiree coverage under this rule is not subsidized.

Disability

There is no subsidized coverage during disability. Employer contributions are required during periods of temporary disability up to a maximum of 90 days while employee is receiving regular compensation.

Covered Employment is Essential

The purpose of this Plan is to provide health care protection to employees working under a Collective Bargaining Agreement, and non-bargaining unit employees of signatory contractors. If you are not working or eligible for work under a Collective Bargaining Agreement or participation agreement, your coverage will end as follows:

IF YOU ARE UNAVAILABLE/INELIGIBLE TO WORK IN COVERED EMPLOYMENT

If you become ineligible to work in covered employment, benefits for you and your dependents will cease immediately, and you will forfeit the hours in your Reserve Hour Bank. This rule will apply if, for example, you accept full-time employment outside the sheet metal industry or you are ineligible for work or if you refuse to work in accordance with the Collective Bargaining Agreement which entitles you to Plan coverage.

Your coverage may be reinstated if you return to covered employment or reinstate *your* eligibility for covered employment within one year of its lapsing. The hours in your Reserve Hour Bank also may be restored.

This provision does not apply if you are covered under a Subscription Agreement with the Plan.

IF YOU WORK IN NON-COVERED SHEET METAL SERVICE

Non-covered sheet metal service is any kind of sheet metal industry work, including "moonlighting", performed in either Northern California or in any other jurisdiction with which the Plan has a Reciprocity Agreement, for an employer which does not contribute to the Sheet Metal Workers of Northern California Pension Plan or Sheet Metal Workers Local 104 Health Care Plan or any reciprocal plan.

For example, work for any non-union sheet metal firm is considered non-covered sheet metal service; it makes no difference whether you perform the work as an employee, as an owner, or just by yourself—or whether or not you are compensated for this work. All such work can lead to loss of benefits described below, with the exception of work as an employee of a government agency or other work recognized by the Trust, or work you perform for yourself on your own property.

Work in non-covered sheet metal service can result in a loss in your Sheet Metal Workers Local 104 Health Care Plan benefits as explained below.

1. Denied Coverage. You will not have coverage, regardless of the number of hours in your Reserve Hour Bank, beginning with the first day in which you work in non-covered sheet metal service. If the Plan is not notified of your non-covered sheet metal service in time to deny coverage in this time frame, the Trustees may, at their discretion, suspend coverage for the appropriate number of months immediately following notification, or retroactively pursue collection of any health care benefits paid on your behalf or on behalf of your dependents during non-covered sheet metal service.

2. Reserve Hour Bank Coverage. Your Reserve Hour Bank will be charged for a full month during any month in which you engage in non-covered sheet metal service.

3. For Active Participants. No self-payment will be allowed for any month for which coverage is lost. In addition, once you have insufficient hours in your Reserve Hour Bank to provide a full month's coverage, you cannot restore future coverage by making self-payments, unless and until you subsequently re-qualify for active or retiree coverage.

4. Retired Participants. Refer to the Retiree Section on page 77.

5. Other Consequences. If the Collective Bargaining Agreement under which you accumulated your Reserve Hour Bank provides for other consequences for non-union sheet metal service, those consequences will be enforced by the Plan. For example, if your Collective Bargaining Agreement so provides, your entire Reserve Hour Bank will be forfeited if you engage in non-union sheet metal service.

How to Enroll

FOR ALL PLAN PARTICIPANTS AND THEIR ELIGIBLE DEPENDENTS

Coverage for yourself and your eligible dependents begins on the first day of the month in which you initially become eligible for benefits or regain eligibility for benefits.

Initial Eligibility

You must complete and submit an enrollment form to the Trust Fund Office, Billing and Eligibility Department, with sufficient documentation for your dependents if necessary (e.g., proof of marriage) within 90 days.

When to Make Your Medical Plan Selection

You are given the opportunity to make your medical plan selection when you first become eligible for benefits under the Plan.

If you fail to submit an enrollment form within 90 days, you will automatically be enrolled in the Indemnity Medical Plan, and **coverage for your eligible dependents will not be effective until the first day of the month in which the dependent is enrolled in the Plan.** The next opportunity to switch plans will be after 12 months. Please see page 28 for more information regarding Open Enrollment.

Residential Utility Workers and Maintenance Service Technicians are only eligible for coverage provided through Kaiser Permanente.

Enrolling New Dependents

Newly acquired eligible dependents, including a new spouse, newborn or stepchild, will be covered from the time of birth, adoption or marriage, provided you complete and submit an enrollment form and appropriate documentation as required **within 90 days of birth, placement for adoption or marriage**. If you enroll your eligible dependent **after** 90 days, coverage for that dependent will be effective the first day of the month in which the dependent is enrolled in the Plan. **Although new dependents born to you are automatically eligible at birth, claims for them will be held pending receipt of enrollment form and documentation**. **Please note: If you acquire a dependent who is eligible for Medicare and enrolls in Kaiser Permanente Senior Advantage (KPSA), coverage will be effective the first of the month following receipt of the enrollment form.**

Residential Utility Workers and Maintenance Service Technicians are not eligible to enroll dependents.

Special Enrollment for Dependents

Eligible Dependents may be enrolled into the Plan if they lose eligibility under Medicaid or a State Sponsored Children's Health Insurance Plan and/ or upon becoming eligible for a special premium assistance subsidy under Medicaid or a State Sponsored Children's Health Insurance Plan. You must file your enrollment form with the Trust Fund Office within 90 days of your Eligible Dependent losing coverage under Medicaid or a State Sponsored Children's Health Insurance Plan or within 90 days of your Eligible Dependent becoming eligible for premium assistance under Medicaid or a State Sponsored Children's Health Insurance Plan. This section

also applies to Eligible Dependent children who lose coverage under a group health plan or individual policy.

Claims for dependents cannot be processed until an enrollment form and proper documentation are received by the Trust Fund Office. Proper documentation means material such as a copy of a legal birth certificate, marriage certificate, adoption records, or proof of court-ordered dependent support (e.g., Qualified Medical Child Support Order).

DESIGNATION OF BENEFICIARY

You must complete a beneficiary card at the time of initial enrollment. If you decide to change your beneficiary, you must complete a new beneficiary card. The initial designation or change of designation will take effect on the date it is received by the Trust Fund Office before death.

Eligible Dependents

Your dependents, as defined below, are also eligible to receive benefits. The following rules apply to retirees as well.

Your eligible dependents are:

1. Your lawful spouse, unless legally separated. If you are legally separated, your spouse is no longer an eligible dependent as of the effective date of the legal separation.

2. If you divorce, your former spouse is no longer an eligible dependent as of the effective date listed on the final dissolution decree.

You must notify the Trust Fund Office immediately of your divorce or legal separation.

3. Your children who have not reached their 26th birthday.

   For purposes of this Plan, your children can include:
   - Your natural children
   - Your legally adopted children (from the date they are placed with you for adoption)
   - Your stepchildren
   - Your foster children, or
   - Children for whom you have been appointed legal guardian

   Grandchildren are not covered unless you have been appointed their legal guardian.

   The Plan will also cover a child if you are required by a Qualified Medical Child Support Order to pay the child's medical expenses and the child will be 18 or younger.

4. Your unmarried children—regardless of age—who were totally disabled on the date their Plan coverage would have ended due to reaching a limiting age provided they are incapable of self-support and depend on you for at least one-half of their maintenance and support. Proof of disability and financial dependence must be submitted to the Trust Fund Office within 60 days of the time coverage would otherwise end. Continued proof will be required periodically. Disabilities that occur after your child is no longer eligible are not covered.

5. Individual Dependent Coverage. Should you and your eligible spouse die, your disabled dependent can be covered as a separate individual if all of the following criteria are met:

   (a) You are eligible for benefits under the Plan before you die;

   (b) Your dependent is eligible for Medicare/Medi-Cal based on a determination of disability;

   (c) Your dependent is covered under the Kaiser Medicare-Risk Program (KPSA);

   (d) Your dependent was covered as a dependent under the Plan immediately prior to reaching age 19;

(e) A self-payment, as determined by the Board of Trustees, must be received by the Plan for each month of coverage on behalf of the disabled dependent;

(f) Separate coverage for the disabled dependent will be maintained upon your death as long as you are covered under the Plan at the time of your death.

6. Your registered domestic partner. The following rules and regulations regarding domestic partner coverage apply:

(a) A registered domestic partner means an adult with whom you have established a domestic partnership in California by filing a Declaration of Domestic Partnership with the appropriate State, City or County agency.

(b) The registered domestic partner is entitled to the same benefits that spouses receive.

(c) A domestic partner's children are eligible for health coverage under the same conditions as the children of employees of their spouses.

(d) **The cost of coverage for your domestic partner (and each of his or her dependents) is taxable income to you.** The Trust Fund Office will report the Fair Market Value of your coverage to the I.R.S. each year as taxable income to you. If you believe your domestic partner meets the definition of dependent under the Internal Revenue Code, you may seek a refund from the I.R.S. You are required to remit the additional federal and state income tax, as well as other required payroll taxes, to the Trust Fund Office.

(e) **Failure to make the necessary payment for Domestic Partner coverage on time will result in termination of the domestic partner coverage.**

(f) **Domestic partners (and their dependents) of retired employees are not covered.**

(g) If the domestic partnership should end, the employee must sign and file with the Trust Fund Office a 'Dissolution of Domestic Partnership' Form declaring that the domestic partnership has ended and the effective date of the dissolution.

(h)Upon dissolution of the domestic partnership, the former partner and any insured dependents will be eligible for COBRA continuation coverage.

Important: You can be held liable for benefit payments made based on any incorrect information about your dependents, such as failing to notify the Trust Fund Office if there is a divorce or if an adoption is rescinded. In addition, you may be liable for other costs incurred by the Plan as a result of the incorrect information. These costs include, but are not limited to, attorney fees, Trust Fund Office costs, other administrative costs, and reasonable interest.

Before allowing a dependent to be added to the Plan, the Trust Fund Office will require documentation such as a marriage certificate, birth certificate, domestic partner certificate, divorce, or remarriage documents, and appropriate income tax information.

A dependent who is in the service of the Armed Forces is not eligible as a dependent but is entitled to purchase COBRA continuation coverage.

When Coverage Ends

Generally, coverage under the Plan ends when you or your dependent no longer meets the requirements for Plan coverage. In many cases, continued coverage is available for a limited period of time. Please see the section on Continuing Plan Coverage beginning on page 14.

COVERAGE WILL END FOR BARGAINING UNIT EMPLOYEES on the earliest of the following dates:

1. The last day of the month in which your Reserve Hour Bank provides the minimum required hours.

EXAMPLE: If you are covered and you stop working in June and have 160 hours left in your Reserve Hour Bank after the deduction for August eligibility, 120 of those hours will provide your eligibility for September. Your eligibility will cease at the end of September because the hours remaining in your Reserve Hour Bank will be less than the 120 hours necessary to provide further eligibility.

2. The first day in which you work in non-covered sheet metal service. (See page 5 for additional information regarding covered employment.)

3. The date you become ineligible to work in covered employment.

4. If you fail to make a self-payment contribution (including COBRA) by the due date, or the date the period of self-payment or COBRA continuation coverage ends.

5. If your employer's contributions are delinquent for six months, no further hours will be credited to your Reserve Hour Bank for hours worked for that employer six months after the contribution first became delinquent. If you refuse the Union's demand to withdraw from your delinquent employer, you will forfeit your Reserve Hour Bank.

6. The date you or your dependent enters full-time military service. Special provisions apply to you if you are a military reservist called to active duty. See page 18 for details.

7. Immediately upon notification to the Trust Fund Office of your employee group withdrawing from the Plan, unless the employee group withdraws as a result of employee group election to terminate the Contribution Agreement, by decertification of a Collective Bargaining Agreement or otherwise, in which case termination of coverage occurs at the same time as termination of the Contribution Agreement. Any Reserve Hour Bank balances are also canceled at the time the Contribution Agreement terminates. An employee group is considered to have withdrawn from the Plan under either of the following circumstances:

a. Where contributions to this Plan on behalf of the employee group are no longer required under a Collective Bargaining Agreement (or Subscription Agreement).

b. Where the Collective Bargaining Agreement (or Subscription Agreement) covering your employee group no longer requires payment of a sum adequate to provide any schedule of benefits under this Plan.

8. The date the Plan is terminated.

COVERAGE WILL END FOR NON-BARGAINING UNIT EMPLOYEES on the earliest of the following dates:

1. The end of the last month for which your employer has paid a contribution on your behalf, plus all contributions required under the Collective Bargaining Agreement.

2. If the Collective Bargaining Agreement has expired, the date when the employer and union reach an impasse with respect to a new Collective Bargaining Agreement.

3. If you are an owner/manager, the first day after the end of a Plan year in which the employer did not make contributions on behalf of a bargaining unit employee for at least 870 hours of employment under the Collective Bargaining Agreement.

4. The date the Plan is terminated.

5. The date the Employer or the Board of Trustees elects to terminate coverage for non-bargaining unit employees.

6. Non-Bargaining Unit Employees are not eligible for subsidized self-pay.

COVERAGE WILL END FOR RETIREES if you stop making required contributions or if the Plan is discontinued. If you lose coverage as a retiree, you cannot regain coverage unless you become eligible again as an active employee.

COVERAGE WILL END FOR YOUR DEPENDENTS on the earliest of the following dates:

1. The date your coverage ends.

2. The date you or your dependent no longer satisfies the Plan's eligibility requirements. Coverage will continue through the last day of the month in which a child attains the limiting age for eligibility. Your dependents may then elect to continue coverage for up to 36 months under the COBRA option described on page 21.

3. If you divorce, your former spouse is no longer an eligible dependent on the date of the final divorce decree. If you legally separate, your spouse is no longer an eligible dependent as of the effective date of the legal separation.

4. The first day of the month following your death, unless your spouse or eligible dependents meets the requirements for survivor coverage described on page 20, or your dependent is disabled and meets the requirements for coverage as a separate individual as described on page 9.

5. The date the Plan is terminated.

6. You or your dependent child may remove your dependent child over the age of 19 one time from the Plan if your dependent child is enrolled in a different group health plan or an individual medical policy. You or your dependent child must make the request to remove the dependent child in writing and provide proof of the other medical coverage. You may re-enroll the dependent child at a later date so long as the child remains an eligible dependent and complete any enrollment forms or any other documents that may be required by the fund office.

SPECIAL RULE FOR DEPENDENT CHILDREN OF RETIREES. The Retiree may remove a dependent child under the age of 19 from the Plan if the dependent child is enrolled in a different group health plan or an individual policy, upon written notification to the Fund Office and proof of enrollment in the group health plan or individual medical policy. A retiree may re-enroll the dependent child at Open Enrollment or when the dependent child who is under the age of 19 at the end of the calendar year loses coverage under the group health plan or

individual policy, provided the dependent child enrolls within 90 days of such loss. See "Special Enrollment for Dependents" for more information.

Continuing Plan Coverage

When certain events occur in your life, protection under the Plan for you and your eligible dependents can continue for a limited period of time.

These life events are:

1. Unemployment or Reduction in Hours
2. Disability
3. Retirement
4. Death
5. Call to Active Military Duty
6. Loss of dependent eligibility due to divorce, legal separation, attaining the limiting age for dependents, etc.

In the event of disability or military call-up, your coverage can be extended for a period of time at no cost. After that, and in the event of unemployment, retirement or death, you or your surviving spouse can use the remaining hours in your Reserve Hour Bank and then continue coverage by paying for it, provided you or your surviving spouse meet the eligibility requirements described in the following pages.

The Plan also includes additional continuation provisions for health care coverage, called COBRA continuation coverage, described on page 21.

If you are covered under a Subscription Agreement with the Plan, some of these continuation of coverage provisions may not apply to you. Instead, there may be special provisions in your Subscription Agreement. If you would like to learn more about your rights to continue Plan coverage, call the Trust Fund Office.

Cost of Continuing Coverage

When you have exhausted the hours in your Reserve Hour Bank and elect to continue Plan coverage, you will be required to pay for your coverage. Your cost will depend on factors such as your employment status, your dependents, your eligibility for Medicare, your retirement date and your status as a Subscription Agreement participant. The cost may also change from time to time to reflect the price of health care services and supplies. Contact the Trust Fund Office for the cost that applies to you.

When Payments are Due

If your coverage is continued due to unemployment or disability, payments must be received by the Trust Fund Office no later than the 20th day of each month for coverage during that month. If your payment is not received by this time, your coverage will end on the first day of the month in which it is due. For example, if you fail to make your payment by April 20, your coverage will have ended on March 31. Once you stop making payments, your coverage cannot begin again until you work enough hours to regain coverage as an active employee.

If your coverage is continued due to retirement or as a Surviving Spouse, payments must be received by the Trust Fund Office no later than the 20th day of the month <u>preceding</u> the month of coverage. If the payment is not received by this time, coverage will end as of the last day of the month for which coverage was paid. For example, if you fail to pay for April coverage by March 20, your coverage will end on March 31.

If You Become Unemployed

If you become unemployed but remain on an out-of-work list, you will remain covered under the Plan for as long as you have enough hours in your Reserve Hour Bank. After that, you can continue coverage for a period of time by making **subsidized self-payments** to the Plan **for up to 12 months**. In order to make subsidized self-payments, you must remain on an out-of-work list and meet the following requirements:

a. Your employer(s) contributed to the Plan on your behalf for at least 500 hours during the 12-month period immediately preceding your unemployment, or

Your employer(s) contributed to the Plan on your behalf for at least 3,000 hours during the 36-month period immediately preceding your unemployment (the Plan will not include periods of disability when reviewing the period immediately preceding your unemployment); and

b. You were covered continuously under this Plan from the date you became unemployed, or you were covered under your spouse's health plan from the date you became unemployed, and applied for coverage under this Plan within 30 days of losing coverage under your spouse's plan. You must submit evidence to the Trust Fund Office that you were (and are no longer) covered under your spouse's plan; and

c. You have not refused work covered under the Collective Bargaining Agreement or otherwise not been available for such work.

If you become eligible for EDD benefits because of "shelter in place" mandates issued by any city, county or the State of California, you will be eligible to continue coverage by making **subsidized self-payments** in accordance with this section. In this limited circumstance, if you provide the Fund Office an EDD check stub with a first claim effective date of March 16, 2020 or later, you will not be required to sign the out-of-work list. The temporary waiver of the requirement that you sign the out-of-work list described in this paragraph will terminate when the Public Health Emergency declared by the Secretary of Health and Human Services ends.

If your break in employment is due to a reduction in your hours of employment, you may be eligible for benefits through the following plans, provided contributions were made on your behalf to either of the following plans, and you satisfy their eligibility rules:

- Supplemental Health Care Benefit (SHC). If you work under a Collective Bargaining Agreement and the wage and fringe schedule requires additional contributions to fund the Supplemental Health Care Benefit, you may be eligible for up to six (6) months of no-cost coverage after your Hour Bank runs out. Refer to page 119 for additional information on eligibility rules for this benefit.

- SASMI Benefit. If you work under a Collective Bargaining Agreement calling for specific contributions to fund the SASMI Benefit and you think you may be eligible for benefits through SASMI, please contact the SASMI Trust Fund Office at (800) 858-0354.

Any Supplemental Health Care (SHC) or SASMI Benefit you receive will apply toward the 12 months of subsidized self-payments available.

The following example illustrates how you could utilize the unemployment benefits described above (assume you have a full Hour Bank and qualify for Supplemental Health Care Benefits at the time you become unemployed):

You become unemployed in August 2007. Your Hour Bank provides coverage for four months. You are then eligible to make subsidized self-payments, but could first utilize the Supplemental Health Care Benefit, if you qualify:

Sep 2007–Dec 2007	Coverage provided by Hour Bank;
Jan 2008–June 2008	Coverage provided by Supplemental Health Care Plan up to 6 months;
Jul 2008–Dec 2008	Make subsidized self-payments for the remaining 6 months.

Please note that you must first qualify for subsidized self-payments in order to further qualify for the Supplemental Health Care Benefit or the SASMI Benefit.

COBRA Benefit. Refer to page 21 for more information regarding COBRA. If you are eligible for benefits through any of the above plans, the maximum number of months you can elect COBRA will be reduced by the number of months of eligibility provided to you by the other program. Your COBRA continuation coverage runs concurrently with any Supplemental Health Care Benefit, SASMI Benefit, and subsidized self-payments you are eligible for.

How Long You Can Continue Coverage

You can continue Plan coverage for up to 12 months if you qualify for subsidized self-pay from the date you no longer have enough hours in your Reserve Hour Bank (reduced by any Supplemental Health Care or SASMI Benefits used.)

For example, assume you become unemployed in May 2006. Also assume that you qualify for Plan coverage for June but do not have enough hours in your Reserve Hour Bank to continue your eligibility beyond that time. Finally, assume that your employer contributed to the Plan on your behalf for 600 hours between May 2006 and May 2007. Therefore, you can continue coverage for the 12-month period beginning July 1, 2007 and ending June 30, 2008, provided you remain on the "Unemployed/Eligible for Work" list, and have not used any Supplemental Health Care or SASMI Benefits.

Applying for Coverage While Unemployed

You must apply for continued coverage under the Plan (and make your first payment) during the first month in which you have insufficient hours in your Reserve Hour Bank.

If you do not begin making payments as soon as you are eligible, you may not start thereafter. However, this rule does not apply if you are covered under your spouse's group health plan when you become unemployed. You must apply for coverage under the Sheet Metal Workers Local 104 Health Care Plan within 30 days of the date coverage under your spouse's plan ceases, and you cannot apply for this Plan's coverage until coverage under your spouse's plan ceases. You will be required to submit evidence to the Trust Fund Office that you were (and are no longer) covered under your spouse's plan.

Residential Utility Workers and Maintenance Service Technicians are not eligible for this benefit.

If You Participate in A Work Share Program

If you are working 104 hours per month or less and are signed on a work share program, you will be eligible to continue your Plan coverage by paying the same rates as unemployed employees. To qualify for these rates, you must meet the self-payment rules for unemployed employees outlined in this section of the booklet; however, you need not be signed on the "Unemployed/Eligible to Work" list. You will be allowed to pay the special rate to continue Plan coverage for as long as you are in a work share program and are working 104 hours per month or less.

If You Become Disabled

You will be considered a disabled employee under the Plan if the illness or injury makes you unable to engage in any work earning more than the gainful activity level per month as set by social security, after you have become disabled. You must report any income in excess of the gainful activity level in a month to the Trust Fund Office by each July 15 and January 15. This amount is set by Social Security and may change from time to time. The illness or injury must occur while your coverage is maintained by your Reserve Hour Bank, but need not occur while you are actually on the job.

If you are disabled, you and your dependents are eligible to receive an additional month of eligibility for every month of your disability, up to a maximum of 12 months, at no cost to you. You will be eligible for another 12 months of no-cost disability coverage after you have returned to work long enough to establish one month of eligibility by active hours.

The maximum period for which coverage will be provided for any one disabling condition and any one period of disability is 12 months. This rule will be waived if you return to work at least 12 consecutive months.

If you are totally or partially disabled, you may be eligible for coverage under the Plan as a retiree. See page 82 for details.

To be eligible, you must notify the Trust Fund Office of your disability within one year of becoming sick or injured. In addition, if the case of the disability is alcoholism or drug abuse, you must enroll for a course of treatment in either an outpatient or inpatient facility coordinated by the Recovery Program described on page 62. You will be required to submit proof to the Trust Fund Office that you have enrolled in a course of treatment.

Using Your Reserve Hour Bank

After your extended coverage ends, Plan coverage will continue for you and your dependents for as long as you have enough hours in your Reserve Hour Bank.

After You Use Your Reserve Hour Bank

If you are still disabled when the eligibility in your Reserve Hour Bank runs out, you may elect to continue Plan coverage by paying for it at the rate established by the Plan. You can use this means of extending coverage for up to 12 months, or you can elect continuation coverage through COBRA. Please see page 21 for details regarding COBRA coverage.

You may further qualify for the Supplemental Health Care Benefit which you may utilize before making subsidized self-payments.

Any Supplemental Health Care (SHC) you receive will apply toward the 12 months of subsidized self-payments available.

The following example illustrates how you could utilize the disability benefits described above (assume you have a full Hour Bank and qualify for Supplemental Health Care Benefits at the time you become disabled):

You become disabled in January 2006. Your Hour Bank provides free coverage for four months. You are then eligible to make subsidized self-payments, but could first utilize the Supplemental Health Care Benefit, if you qualify:

Jan 2006–Dec 2006	12 months of disability coverage provided by Plan;
Jan 2007–Apr 2007	Coverage provided by Hour Bank;
May 2007–Oct 2007	Coverage provided by Supplemental Health Care Plan up to 6 months;
Nov 2007–Apr 2008	Make subsidized self-payments for the remaining 6 months.

Applying for Continued Coverage While Disabled

When you apply for continued coverage, you must submit proof of your disability. This proof must include: (a) disability dates (beginning and ending, including any updated disability extensions from your doctor), (b) diagnosis or ICDA code, (c) doctor's signature. Continued proof of your disability will be required by the Trust Fund Office, and the Plan reserves the right to request certification of your disability in writing from two (2) of your treating physicians to be certified as disabled.

Once you have used all available no-cost coverage, you **must** elect to extend your coverage during the first month your Reserve Hour Bank runs out in order to continue coverage while you are disabled by paying for coverage that starts that month. From then on, you must continue paying by the 20th of the month for the extended coverage.

There is no subsidized coverage during disability if you are covered under a Subscription Agreement with the Plan. Call the Trust Fund Office for more information.

You must be eligible for covered employment once disability ends to continue coverage under the Plan.

Residential Utility Workers and Maintenance Service Technicians are not eligible for this benefit.

If You Are A Military Reservist Called to Active Duty

If you are in the U.S. Military Reserve and you are called to active duty, by providing evidence of your status, you and your covered dependents will be covered under the Plan, at no cost to you, for each month you serve—up to twelve months. Your benefits will be provided under the schedule for which your employer was contributing when you were activated into the service.

Residential Utility Workers and Maintenance Service Technicians are not eligible for this benefit.

If you are still on active duty at the end of twelve months, your coverage will continue through your Reserve Hour Bank. When that runs out, you may continue your coverage by paying for it. At the end of the six months, you may apply for continuing coverage for up to 18 months, and your monthly payment is based on 102% of the cost of your coverage. You may continue your coverage for up to 24 months in total. Your COBRA continuation coverage runs concurrently with any benefits you may be entitled to under the Uniformed Services Employment and Re-employment Rights Act of 1994.

Applying for Coverage While on Active Duty

You must elect to extend your coverage during the first month your Reserve Hour Bank runs out by paying for coverage that starts that month. From then on, you must continue paying by the 20th of the month for the extended coverage.

Alternatively, you may elect to freeze your hour bank as of the date of your call-up until the date of your discharge by notifying the Fund Office in writing within 30 days of your call-up date.

If You Retire

If you retire, you may be eligible to continue coverage under the terms of the Sheet Metal Workers Local 104 Retiree Health Plan. Please see page 77 for more information regarding terms and eligibility rules under the Retiree Plan.

If You Transfer to Another Area

If you transfer outside the Northern California Region, you may be able to continue this Plan's eligibility and coverage under a Reciprocity Agreement—an arrangement between this Plan and other unions outside the area. Residential Utility Workers and Maintenance Service Technician are not eligible for this benefit.

The Plan has entered into reciprocity agreements with the Northern California Sheet Metal Workers Health Care Plan, the Northwest Sheet Metal Workers' Welfare Plan, and the Sheet Metal Workers' Welfare Plan of Southern California, Arizona, and Nevada. The Plan has also entered into reciprocity with all other Sheet Metal Workers Local Unions signatory to the Sheet Metal Workers International Association Standard Form of Reciprocity Agreement.

If you transfer to a geographic area covered by one of the above Sheet Metal Workers Health Care Plans, you should inform the Trust Fund Office before you leave the area to which you plan to transfer. Upon your arrival there, you should contact the plan involved. They will determine what rights, if any, you have under the Reciprocity Agreement.

Once you have signed a reciprocity agreement, it will be in effect until you issue a 'stop agreement' with the Trust Fund Office. If you have any questions about reciprocity, call the Trust Fund Office.

If You Die

If you die **while you are employed**, coverage for your eligible surviving spouse and children will continue for as long as you have enough hours in your Reserve Hour Bank. If you die **while you are retired**, coverage for your eligible surviving spouse and children will continue for as long as the appropriate self-payments are made. Children include adopted children, even if the adoption has not yet been finalized.

After Your Reserve Hour Bank Is Insufficient

When there are no longer sufficient hours in your Reserve Hour Bank, your surviving spouse and/or your eligible dependents may elect to continue coverage.

Your spouse and/or eligible children must enroll during the month in which the first payment for Plan coverage is due. Your newborn children may become covered if an Enrollment Form is submitted within 90 days of birth. These are the only times when surviving children may be added to the Plan.

If your surviving spouse remarries, neither he/she nor his/her new spouse will be covered under the Plan. Newborn children and stepchildren from the new marriage will not be covered.

Applying for Survivor Coverage

A notice will be sent from the Trust Fund Office to your surviving spouse or other eligible dependent(s) explaining his or her rights to Plan coverage. Your surviving spouse or other eligible dependent(s) must elect to continue coverage (and make the first payment) by the end of the month following the month he or she receives the notice. For example, if your surviving spouse receives the notice on March 15, he or she must submit an election form and payment to the Trust Fund Office by April 30. Coverage may be made retroactive to the date of your death.

If your surviving spouse or other eligible dependent stops making the monthly payments, survivor coverage will end and cannot be reinstated.

All surviving spouses or other eligible dependent(s) of active or retired participants, if they elect survivor coverage, will be covered under the Retiree Health Plan.

COBRA Continuation Coverage

The Plan offers covered employees and their dependents the opportunity to elect a temporary extension of health coverage (called "COBRA Continuation Coverage") in certain instances (called "qualifying events") where coverage under the Plan would otherwise end. To receive this continuation coverage the employee, spouse and/or dependent(s) must pay timely monthly payments directly to the Trust. The monthly COBRA payments must be concurrent; you may not skip a payment during the COBRA continuation coverage period.

When you no longer have sufficient hours in your Reserve Hour Bank, your COBRA coverage will run concurrently with any continuation of coverage described beginning on page 14. In other words, your COBRA eligibility is reduced by the number of months of free or subsidized coverage provided in the event of unemployment, disability or death.

RIGHTS OF COVERED EMPLOYEE

If you are an employee covered by the Plan, you may have a right to choose this continuation coverage if you lose your group health coverage because of termination of your employment or a reduction in your hours.

Even if you do not elect COBRA continuation coverage, your spouse, domestic partner, and each of your eligible dependents has a separate right to elect it. You, your spouse and all your eligible dependents should read this section of your benefit booklet.

RIGHTS OF DEPENDENT SPOUSE

If you are the spouse or domestic partner of a covered employee, you may have the right to elect continuation coverage for yourself if you lose coverage under the Plan for any of the following reasons:

A reduction in the employee's hours;

Termination of the covered employee;

Death of the covered employee;

Divorce from the covered employee.

RIGHTS OF DEPENDENT CHILDREN

If you are the dependent child of a covered employee, you may have the right to elect continuation coverage for yourself if you lose coverage under the Plan for any of the following reasons:

A reduction in the employee's hours;

Termination of the covered employee;

The death of a parent who is the covered employee under the Plan; or

You cease to be an eligible dependent as defined by the Plan.

PERIOD OF COBRA CONTINUATION COVERAGE

Qualifying Event	Qualified Beneficiary	Maximum Continuation Period
Reduction in covered Employee's hours	Employee, spouse, domestic partner and dependent children	18 months after date Of qualifying event
Termination of covered employee's employment	Employee, spouse, domestic partner And dependent children	18 months after date of qualifying event
Death of covered Employee	Spouse, domestic partner and Dependent children	36 months after date of qualifying event
Divorce or legal separation of covered employee; dissolution of domestic partnership	Spouse or domestic partner	36 months after date of qualifying event
Dependent child's Loss of dependent Status under Plan	Affected dependent child	36 months after date of initial qualifying event
Covered employee's entitlement to Medicare after a qualifying event described in (1) or (2)	Spouse, domestic partner and Dependent children	36 months after date of initial qualifying event
Covered employee's Entitlement to Medicare Before a qualifying event Described in (1) or (2)	Spouse, domestic partner and Dependent children	36 months after date of initial qualifying event

Disability Extension. For an additional charge and subject to certain notice requirements, the 18-month maximum continuation period under the Plan shown in the table above may be extended up to 29 months from the qualifying event for any individual (and his or her eligible family members) with a Social Security Disability award within a period of up to 60 days following the time of the reduction or termination of employment. Notice of the disability award must be provided to the Trust Fund Office within 60 days after it is issued and within the initial 18-month period of COBRA eligibility. The 11-month disability extension period will end if the disabled individual recovers before the end of the extension period. Contact the Trust Fund Office for further details about this disability extension.

MULTIPLE QUALIFYING EVENTS

If you or your covered dependent elects COBRA coverage due to your termination of employment or reduction in hours, your covered dependent(s) will be entitled to additional coverage up to a total of 36 months if, during the first 24 months:

You die;

You divorce;

You become entitled to Medicare benefits; or

Your child no longer qualifies for coverage under the terms of the Plan.

The maximum continuation period is 36 months, even if more than one event occurs giving rise to COBRA continuation rights.

TERMINATION OF COBRA COVERAGE

COBRA continuation coverage will end before the 18-, 29- or 36- month continuation coverage period expires if:

You or your dependents fail to pay the required contribution on a timely consecutive monthly basis;

You or your dependents become covered by another group health plan after you or your dependents elect COBRA coverage, except a plan that excludes or limits benefits for a pre-existing condition affecting your dependent and such exclusion or limitation is enforceable under the Health Insurance Portability and Accountability Act (HIPAA);

You or your dependents become entitled to Medicare after you or your dependents elect COBRA coverage;

Your employer ceases to maintain any health plan for active employees; or

You or your dependents qualified for the 29-month maximum continuation period based on disability, but are no longer disabled.

Continuation coverage will no longer be available under this Plan if this Plan terminates.

DUTY TO NOTIFY THE TRUST FUND

Coverage for a spouse ends on the date of divorce or legal separation. However, the spouse has the right to pay for COBRA continuation coverage. Without COBRA payments, no benefits will be paid on behalf of a former spouse. COBRA coverage can last up to 36 months. You or your former spouse must provide written notice of the divorce and a copy of the final divorce decree or notice of legal separation to the Trust Fund Office within 60 days after the final decree is entered. If notice is not provided within the time allowed, COBRA self-payment will not be permitted.

Coverage for a dependent child ends on the date the child no longer qualifies as your dependent. However, the child has the right to pay for COBRA continuation coverage. Without COBRA payments, no benefits will be paid on behalf of a former dependent child. COBRA continuation coverage can last up to 36 months. You or your child must provide written notice

of the loss of dependent status within 60 days of the loss of status. If notice is not provided within the time allowed, COBRA self-payment will not be permitted.

No benefits will be paid without COBRA payments. The Trust Fund Office must be notified in writing when divorce occurs or when a child loses dependent status. Notice must be given within 60 days after the later of (1) the divorce or loss of dependent status, or (2) the actual loss of coverage. If the required notice is not provided within the time allowed, COBRA self-payments will not be permitted.

No benefits are payable after the loss of dependent status. You will be required to refund any benefit payments issued for expenses incurred after the termination of coverage.

ELECTION OF COBRA COVERAGE

Within 60 days after the Trust Fund Office is informed in writing of an event entitling you and/or your spouse or dependent children to COBRA coverage, the Fund will provide detailed information concerning the coverage available and its cost. You and/or your dependent must elect COBRA coverage within 60 days after your coverage under the Plan ends or the date you receive the election form, whichever is later. Anyone electing COBRA coverage must pay for it retroactive to the date he or she lost coverage under the Plan. Payment for this retroactive coverage is due within 45 days after the date COBRA coverage is elected. No benefit claim will be honored unless the required payment has been received for the period in which the claim was incurred.

If you elect COBRA continuation coverage, you will be entitled to the same health coverage that is provided to active employees or family members in the Plan. Therefore, if there are any changes to the Plan for active employees, your benefits will change. The death benefit and Accidental Death and Dismemberment (AD&D) benefit are not provided under COBRA continuation coverage.

Please note: You have the option of electing one of the following COBRA Plans:

1. CORE COVERAGE
   Provides coverage for medical and prescription drugs.

2. FULL COVERAGE: CORE AND NON-CORE
   Provides coverage for medical, prescription drugs, dental, vision exam and alcohol and drug coverage.

Once you elect Core Coverage or Full Coverage, you cannot change your election.

EXTENDED COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT

Your employer must continue to pay for your health coverage during any approved leave under the federal Family and Medical Leave Act (FMLA). In general, you may qualify for up to 12 weeks of unpaid FMLA leave per year if:

1. Your employer has at least 50 employees (including both bargaining unit or non-bargaining unit employees);

2. You worked for the employer for at least 12 months and for a total of at least 1250 hours during the most recent 12 months; and

3. You require leave for one of the following reasons:

   (a) Birth or placement of a child for adoption or foster care,

   (b) To care for your child, spouse or parent with a serious medical condition, or

   (c) Your own serious health condition. Details concerning FMLA leave are available from your employer.

Requests for FMLA leave must be directed to your employer; the health plan cannot determine whether or not you qualify. If a dispute arises between you and your employer concerning your eligibility for FMLA leave, you may continue your health coverage by making COBRA self-payments. If the dispute is resolved in your favor, the health plan will obtain the FMLA-required contributions from your employer and will refund the corresponding COBRA payments to you.

If your employer continues your coverage during an FMLA leave and you fail to return to work, you may be required to repay the employer for all contributions paid to the Health Plan for your coverage during the leave.

CERTIFICATE OF FORMER GROUP HEALTH PLAN COVERAGE

The certificate of former group health plan coverage provides evidence of your health coverage under the Sheet Metal Workers Local 104 Health Care Plan. If you become covered under a new group health plan that excludes coverage for certain medical conditions, you may need to furnish the certificate to the new plan administrator. You may also need this certificate to buy, for yourself or your family, an insurance policy that does not exclude coverage for medical conditions that are present before you enroll.

If you or your dependent lose coverage under the Plan, you will be furnished with a certificate of former plan coverage. You may need the certificate if your new plan excludes coverage for pre-existing conditions. If you are entitled to COBRA coverage, the certificate will be mailed when a notice for a qualifying event under COBRA is required, and after COBRA coverage stops. You may also request a certificate within 24 months after losing coverage.

DISCLOSURE OF PROTECTED HEALTH INFORMATION

Disclosure

The Plan and any Business Associate, as defined below, will disclose your Protected Health Information to the Board of Trustees only to permit the Board of Trustees to carry out plan administrative functions for the Plan not inconsistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. §§ 160-64). Any disclosure to and use by the board of Trustees of your Protected Health Information will be subject to and consistent with this section.

Restrictions on Use and Disclosure of Protected Health Information

1. The Board of Trustees will not disclose your Protected Health Information, except as permitted or required by the Notice of Privacy and the Privacy Rule, as amended, or required by law.

2. The Board of Trustees will ensure that any agent, including any subcontractor, to whom it provides your Protected Health Information agrees to the restrictions and conditions of the Plan Documents, including this section, with respect to your Protected Health Information.

3. The Board of Trustees will not use or disclose your Protected Health Information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Board of Trustees.

4. The Board of Trustees will report to the Plan any use or disclosure of your Protected Health Information that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.

5. The Board of Trustees will make Protected Health Information available to the Plan Participant who is the subject of the information in accordance with 45 C.F.R. § 164.524.

6. The Board of Trustees will make your Protected Health Information available for amendment, and will on notice amend your Protected Health Information, in accordance with 45 C.F.R. § 164.526.

7. The Board of Trustees will track disclosures it may make of your Protected Health Information so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528.

8. The Board of Trustees will make its internal practices, books, and records, relating to its use and disclosure of your Protected Health Information, to the Plan and to the U.S. Department of Health and Human Services to determine compliance with 45 C.F.R. § 160-64.

9. The Board of Trustees will, if feasible, return or destroy all your Protected Health Information, in whatever form or medium (including any electronic medium under the Board of Trustees custody or control), received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any Participant who is the subject of the Protected Health Information, when your Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all your Protected Health Information, the Board of Trustees will limit the use or disclosure of any of your Protected Health Information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information feasible.

Authorization

Authorization is required for the use and disclosure of your Protected Health Information for purposes other than the permitted uses and disclosures specified in the Privacy Rule. When your authorization is needed, you will be asked to fill out an authorization form. The signing of the form is completely voluntary, and once signed, may be revoked in writing at any time.

Definitions

Business Associate means a person or entity who provides certain functions, activities or services to the Sheet Metal Workers Local 104 Health Care Plan involving the use and/or disclosure of Protected Health Information.

SECURITY STANDARDS FOR ELECTRONIC PROTECTED HEALTH INFORMATION

1. The Board of Trustees will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan.

2. Adequate separation required by 45 C.F.R § 164.405(f)(2)(iii) will be supported by reasonable and appropriate security measures.

3. The Board of Trustees will ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information, agrees to implement reasonable and appropriate security measures to protect the information.

4. The Board of Trustees will report to the Plan any security incident of which it becomes aware promptly upon learning of such security incident.

5. The Board of Trustees will make its policies and procedures and documentation relating to these safeguards available to the Department of Health and Human Services for purposes of determining the Plan's compliance with 45 C.F.R. § 164.314(b).

Electronic Protected Health Information shall have the same meaning as the term "electronic protected health information" in 45 C.F.R. § 160.103.

Open Enrollment (Actives and Retirees)

MEDICAL BENEFITS
Two medical benefit plan options are currently available to you and your eligible dependents:

(1) **A prepaid health plan provided through Kaiser Permanente**. Kaiser Permanente Health Plan is a Health Maintenance Organization (HMO). You must live or work within the Kaiser service area in order to enroll in Kaiser. If you are not sure if you live or work within the Kaiser service area, please contact the Fund Office for assistance. If you enroll in Kaiser, you and your eligible dependents will be covered under Kaiser for all hospital and medical services and supplies. **However, the Fund will continue to provide you with dental, hearing aid, alcohol and substance abuse, death, and accidental death and dismemberment benefits directly through the Indemnity Plan and other applicable prepaid plans**.

(2) **An Indemnity Plan provided directly by the Trust Fund**. If you are enrolled in this option, you and your eligible dependents will be covered under the Indemnity Medical Plan for hospital and medical services and supplies. It is recommended that you go to a Preferred Provider Organization (PPO) facility which will reduce your out-of-pocket expenses, as explained in this Booklet on page 46.

DENTAL BENEFITS
You and your eligible dependents will be covered under the Delta Dental Plan for dental services

When to Make Your Health Plan Selection
When you first become eligible for health care benefits, you must complete an Enrollment Form and indicate your choice of medical plans (Indemnity Medical Plan or Kaiser.)

The Plan maintains a 'rolling' Open Enrollment. You have the opportunity to change your medical plan anytime during the year, as long as you have not changed plans in the last consecutive 12 months. The only exceptions will be if you move out of the Kaiser service area (in which case you must enroll in the Indemnity Medical Plan), or a change is approved by the Board of Trustees. If you become eligible for Medicare and you are covered under Kaiser, you must enroll in the Kaiser Permanente Senior Advantage Plan—see page 86 for details. **Any change in plan(s) will be effective on the first day of the second calendar month following the date the enrollment form is received by the Trust Fund Office**. For example, if you elect to change from the Indemnity Medical Plan to Kaiser and the Trust Fund Office receives your enrollment form on October 23, 2011, your coverage effective date under Kaiser will be December 1, 2011 and the next possible date you can change plans is December 1, 2012.

When a change is made, an anniversary date for that plan is established. This anniversary date will be used to determine when future changes may be allowed. Please remember that your eligible dependents will be enrolled in the same plan as you. Details on the different Plans will be mailed to you upon request. Contact the Trust Fund Office for more information on the different medical and dental plans if you are considering changing.

Any applicable deductible amounts are applied separately to each Plan. If you choose to change Plans in the middle of a calendar year, you will be subject to the deductibles that apply under the Plan you are enrolled in regardless of if you previously met the deductible under the other Plan in the same calendar year.

If you switch back to the Indemnity Plan after having been enrolled in Kaiser, prior benefit usage under the Indemnity Plan will be taken into account in calculating the maximum benefits available for non-Essential Health Benefits.

If you choose the Indemnity Health Plan, benefits will be paid for your medically necessary covered services provided by the licensed hospital, licensed physician or other licensed provider of your choice for the treatment of non-occupational illnesses and injuries. Benefits are paid in accordance with Plan provisions established by the Trustees. You are responsible for any differences between what the Plan allows and the fees charged by the health care provider. **You can save yourself and the Plan money by using hospitals, physicians, laboratories and radiologists who have preferred provider contracts with the Plan, and by complying with the Utilization Review Program**.

A summary of benefits begins on page 34 of this booklet.

A description of covered services begins on page 48.

RESIDENTIAL UTILITY WORKERS AND MAINTENANCE SERVICE TECHNICIANS
Kaiser Permanente is the only benefit plan option currently available to you. The coverage offered is single coverage, meaning there is no coverage offered for eligible dependents. A description of the benefits provided under the Kaiser plan can be found on page 30.

Kaiser Health Plan

(Group No. 8417)

Health Maintenance Organization (HMO) Option

Attention Medicare-eligible Retirees: See page 86 for information regarding the Kaiser Senior Advantage Program.

If you live or work within Kaiser's Service Area and are eligible for medical benefits, you have the option to enroll yourself and your eligible dependents in the Kaiser Permanente Health Plan (HMO) option. Kaiser Permanente is available in many locations and offers most services through its physicians and medical facilities. **When you choose the Kaiser Health Plan option, medical benefits, except the dental, alcohol and substance abuse and hearing aid benefits described elsewhere in this booklet, will be limited to those provided through Kaiser Permanente**.

Kaiser does not provide health benefits for participants residing out of the state of California. If you wish to live outside of California and remain a Kaiser member, you must obtain individual coverage through Kaiser and dis-enroll from the Sheet Metal Workers Local 104 Health Care Plan. If you prefer to remain covered under the Sheet Metal Workers Local 104 Health Care Plan, you must choose the Indemnity Health Plan and dis-enroll from Kaiser.

PRESCRIPTION DRUG BENEFITS FOR KAISER PARTICIPANTS

Participants who choose the Kaiser Health Plan must obtain their prescription drugs from a Kaiser facility under the terms of the Kaiser Health Plan. A $10 copayment for generic drugs ($30 for brand name drugs) will be required for each prescription. Prescriptions may be purchased up to a 30-day supply. See page 65.

Office visits and many of the services you receive at Kaiser are subject to a copayment. Copayments are due at the time of service, otherwise an administrative charge may apply.

As of July 1, 1998, Kaiser Permanente Health Plan *may not*:

(1) Limit the length of hospital stay for newborn children and their mothers following a vaginal delivery to less than 48 hours.

(2) Limit the length of hospital stay for newborn children and their mothers following a cesarean section to less than 96 hours.

Summary of Benefits for Kaiser Permanente – Active and Non-Medicare Retiree

(GROUP NO. 8417)

The Services described below are covered only if all the following conditions are satisfied:

- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician
- You receive the Services from Plan Providers inside our Service Area, except where specifically noted to the contrary for authorized referrals, our visiting member program, Emergency Care, Out-of-Area Urgent Care, and Post-stabilization Care described in the ***Evidence of Coverage***. Note: Please refer to *Your Guidebook* for the types of covered Services that are available from each Plan Facility, because at some facilities only specific types of covered Services are provided

The Summary of Benefits is subject to revision.

Proposed Benefit Summary

8417 SHEET METAL WORKERS

Principal Benefits for
Kaiser Permanente Deductible HMO Plan (9/1/20—8/31/21)

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Out-of-Pocket Maximum(s) and Deductible(s)

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

For Services that are subject to the Plan Deductible or the Drug Deductible, you must pay Charges for covered Services you receive during the Accumulation Period until you reach the deductible amounts listed below. All payments you make toward your deductible(s) apply to the Plan Out-of-Pocket Maximum amounts listed below.

Amounts Per Accumulation Period	Self-Only Coverage (a Family of one Member)	Family Coverage Each Member in a Family of two or more Members	Family Coverage Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$3,000	$3,000	$6,000
Plan Deductible	$300	$300	$600
Drug Deductible	None	None	None

Professional Services (Plan Provider office visits)	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits	$20 per visit (Plan Deductible doesn't apply)
Most Physician Specialist Visits	$40 per visit (Plan Deductible doesn't apply)
Routine physical maintenance exams, including well-woman exams	No charge (Plan Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Plan Deductible doesn't apply)
Family planning counseling and consultations	No charge (Plan Deductible doesn't apply)
Scheduled prenatal care exams	No charge (Plan Deductible doesn't apply)
Routine eye exams with a Plan Optometrist	No charge (Plan Deductible doesn't apply)
Urgent care consultations, evaluations, and treatment	$20 per visit (Plan Deductible doesn't apply)
Most physical, occupational, and speech therapy	$20 per visit after Plan Deductible
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	20% Coinsurance after Plan Deductible
Allergy injections (including allergy serum)	No charge after Plan Deductible
Most immunizations (including the vaccine)	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests	$10 per encounter (Plan Deductible doesn't apply)
Preventive X-rays, screenings, and laboratory tests as described in the *EOC*	No charge (Plan Deductible doesn't apply)
MRI, most CT, and PET scans	20% Coinsurance up to a maximum of $50 per procedure (Plan Deductible doesn't apply)
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	20% Coinsurance after Plan Deductible
Emergency Health Coverage	**You Pay**
Emergency Department visits	20% Coinsurance after Plan Deductible
Note: This Cost Share does not apply if you are admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).	
Ambulance Services	**You Pay**
Ambulance Services	$150 per trip after Plan Deductible
Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy	$10 for up to a 30-day supply (Plan Deductible doesn't apply)
Most generic refills through our mail-order service	$20 for up to a 100-day supply (Plan Deductible doesn't apply)
Most brand-name items at a Plan Pharmacy	$30 for up to a 30-day supply (Plan Deductible doesn't apply)
Most brand-name refills through our mail-order service	$60 for up to a 100-day supply (Plan Deductible doesn't apply)
Most specialty items at a Plan Pharmacy	$30 for up to a 30-day supply (Plan Deductible doesn't apply)

(continues)

8417 SHEET METAL WORKERS

Principal Benefits for Kaiser Permanente Senior Advantage (HMO) with Part D (9/1/2020—8/31/2021)

Plan Out-of-Pocket Maximum	
For Services subject to the maximum, you will not pay any more Cost Share for the rest of the calendar year if the Copayments and Coinsurance you pay for those Services add up to the following amount: For any one Member	$1,500 per calendar year
Plan Deductible	None
Professional Services (Plan Provider office visits)	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	$20 per visit
Most Physician Specialist Visits	$20 per visit
Annual Wellness visit and the "Welcome to Medicare" preventive visit	No charge
Routine physical exams	No charge
Routine eye exams with a Plan Optometrist	No charge
Urgent care consultations, evaluations, and treatment	$20 per visit
Physical, occupational, and speech therapy	$20 per visit
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$20 per procedure
Allergy injections (including allergy serum)	No charge
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Manual manipulation of the spine	$20 per visit
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$250 per admission
Emergency Health Coverage	**You Pay**
Emergency Department visits	$50 per visit
Ambulance Services	**You Pay**
Ambulance Services	$150 per trip
Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy	$10 for up to a 30-day supply, $20 for a 31- to 60-day supply, or $30 for a 61- to 100-day supply
Most generic refills through our mail-order service	$10 for up to a 30-day supply or $20 for a 31- to 100-day supply
Most brand-name items at a Plan Pharmacy	$25 for up to a 30-day supply, $50 for a 31- to 60-day supply, or $75 for a 61- to 100-day supply
Most brand-name refills through our mail-order service	$25 for up to a 30-day supply or $50 for a 31- to 100-day supply

(continues)

Indemnity Health Plan

Summary of Benefits

(Actives and Retirees)

Initial Cash Deductible:		
Active, Non-bargaining unit participants, and Non-Medicare Retiree		$300 individual/$600 family maximum per calendar year
Medicare Retirees		None
In-Patient Hospital charges:		
Contract (PPO) hospitals (subject to UR*)		80% of PPO contract rate
Non-PPO hospitals (subject to UR*) person		65% of UCR charges, **AND** a $200 per hospital deductible for each non-emergency admission
Out-Patient Hospital charges:		
Contract (PPO) hospital		80% of PPO contract rate
Non-PPO hospital		65% of UCR charges
Surgeon's and Physician's Fees	**—PPO**	80% of PPO contract rate;
	—Non-PPO	65% of UCR charges
Anesthesiologist's Fees charges		80% of PPO contract rate or 80% of UCR
X-rays and Laboratory Tests	**—PPO**	80% of PPO contract rate;
	—Non-PPO	65% of UCR charges
Skilled Nursing Care Facility	**—PPO**	80% of negotiated rate;
	—Non-PPO	65% of UCR charges
Chiropractic Benefit		
Maximum Per Treatment		$60
Maximum Per Calendar Year		$1,560
Maximum Visits Per Year		26
(Initial consultation and x-rays are covered the same as any other disability.)		
Mental Health Benefit		
Inpatient	**—PPO**	80% of PPO contract rate;
	—Non-PPO	65% of UCR charges
Outpatient		
Maximum Per Treatment	**—PPO**	80% of PPO contract rate;
	—Non-PPO	65% of UCR charges

Emergency care, as defined by the Plan, provided by a Non-PPO provider will be paid at the PPO rate, until the patient can be transferred to treatment with a PPO provider.

* UR means Utilization Review as described on page 40 of this booklet.

UCR means Usual, Customary and Reasonable, as defined by the Plan on page 111.

The terms "PPO", "contract hospital", "contract provider" and "preferred provider" are used interchangeably.

The terms "non-PPO", "non-contract hospital", "non-contract provider" and "non-preferred provider" are used interchangeably.

PRESCRIPTION DRUG BENEFIT

Indemnity Plan Participants Only
(Kaiser Participants must use a Kaiser facility to obtain prescription drugs)

Prescription drugs are covered through WellDyneRx. See page 65 for a more detailed description of your prescription drug benefits.

RETAIL: (purchased at a network pharmacy) **30-Day Supply**

GENERIC:	Tier 1—$15 copayment
PREFERRED BRAND: (Formulary)	Tier 2—25% of the cost of the prescription (with a minimum $15 copay and a maximum $50 copay, per Rx)
NON-PREFERRED BRAND: (Non-Formulary)	Tier 3—25% of the cost of the prescription (with a minimum $15 copay, per Rx, but no maximum); ***Your copayment does not apply to your annual out-of-pocket maximum.***
SPECIALTY: (Formulary)	Tier 4—20% of the cost of the prescription (with a minimum $15 copay and a maximum $50 copay, per Rx). LIMITED TO 30 DAY SUPPLY
SPECIALTY: (Non-Formulary)	Tier 4—20% of the cost of the prescription (with a minimum $15 copay, per Rx, but no maximum). LIMITED TO 30 DAY SUPPLY. ***Your copayment does not apply to your annual out-of-pocket maximum.***
BRAND (If Generic avail):	$15 **plus** the entire difference between the Brand price and Generic price. ***Your copayment does not apply to your annual out-of-pocket maximum.***

MAIL: (purchased through WellDyneRx's Mail Order Pharmacy) **90-Day Supply**

Mail Order copayments are two-times the Retail copayments. If Retail copayments are changed, the Mail Order copayments will change accordingly.

GENERIC:	Tier 1—$30 copayment
PREFERRED BRAND *: (Formulary)	Tier 2—50% of the cost of a 30-day supply (with a minimum $30 copay and a maximum $100 copay, per Rx)
NON-PREFERRED BRAND: (Non-Formulary)	Tier 3—50% of the cost of a 30-day supply (with a minimum $30 copay, per Rx, but no maximum); ***Your copayment does not apply to your annual out-of-pocket maximum.***
SPECIALTY: (Formulary)	Tier 4—20% of the cost of the prescription (with a minimum $15 copay and a maximum $50 copay, per Rx). LIMITED TO 30 DAY SUPPLY
SPECIALTY: (Non-Formulary)	Tier 4—20% of the cost of the prescription (with a minimum $15 copay, per Rx, but no maximum). LIMITED TO 30 DAY SUPPLY. ***Your copayment does not apply to your annual out-of-pocket maximum.***
BRAND (If Generic avail):	$30 **plus** the entire difference between the Brand price and Generic price. ***Your copayment does not apply to your annual out-of-pocket maximum.***

NON-NETWORK PHARMACY: You will be reimbursed by WellDyneRx up to the amount WellDyneRx would have paid at an WellDyneRx retail pharmacy. ***If you use a non-network pharmacy, your copayment does not apply to your annual out-of-pocket maximum.***

HEARING AID BENEFIT

(Indemnity and Kaiser Plan Participants)

The Plan pays 80% up to $2,000 in benefits for the first aid and $1,000 for the second aid, as medically necessary. Rather than purchase a new hearing aid, you can repair your existing aid and the Plan will pay up to the same limit.

ALCOHOL AND SUBSTANCE ABUSE PROGRAM BENEFIT

(Indemnity and Kaiser Plan Participants)

Detoxification

Detoxification requires preauthorization from Blue Shield. The Plan pays up to 80% of the contract rate for PPO providers. Non-preferred providers are paid at 65% of UCR charges. Detoxification is paid under the medical plan and is therefore subject to the same Plan rules as any other hospitalization.

(Kaiser participants must use Kaiser facilities for detoxification)

Inpatient Rehabilitation **(Requires preauthorization by Beat It, see page 62 for details)**

1st Occurrence

- Beat It provider 100% of contract rate
- Non-Beat It provider 65% of UCR charges

Subsequent Occurrences

- Beat It provider 80% of contract rate
- Non-Beat It provider 65% of UCR charges

Outpatient Treatment

- Beat It provider 100% of contract rate
- Non-Beat It provider 65% of UCR charges

Emergency care, as defined by the Plan, provided by a Non-PPO provider will be paid at the PPO rate, until the patient can be transferred to a PPO provider.

Medical Benefits

(Hospital, Medical and Surgical)

The medical coverage portion of the Sheet Metal Workers Local 104 Health Care Plan is designed to help pay many of the health care expenses for you and your covered dependents.

Although the Plan covers a wide array of medical expenses, it is not designed to pay every medical expense you might have. Rather, the goal of the Plan is to help protect you from high medical costs associated with a serious illness or injury. For example:

- The Plan only pays expenses which are medically necessary. Expenses such as cosmetic surgery and other services and supplies which are not medically necessary are not covered by the Plan. The Plan does not pay for expenses that are paid by some other source or are specifically excluded.
- The Plan only pays expenses which are cost-effective or required for treatment. For example, the Plan does not pay the extra cost for your stay in a hospital for surgery when the procedure could have been done safely and effectively in your doctor's office. You can find out whether a proposed hospitalization meets the Plan's guidelines by calling Blue Shield. See page 40 and follow the information regarding Utilization Review Program.
- The Plan pays benefits based on what it considers a "reasonable and customary" charge. The charges above this level are not covered.

OUT-OF-POCKET MAXIMUM

The Plan limits your share of eligible out-of-pocket expenses to $2,500 individual/$5,000 family each calendar year.

The $2,500/$5,000 Out-of-Pocket Maximum does ***not*** include the following:

1. Expenses relating to the use of non-PPO providers, **unless** the benefits paid to non-PPO providers are for emergency treatment as defined by the Plan for a major traumatic injury. In addition, expenses relating to the use of non-PPO providers will count toward your out-of-pocket maximum if the covered services are performed by a non-PPO anesthesiologist and/or assistant surgeon in conjunction with surgery performed at a PPO hospital by a PPO surgeon.
2. Your $200 hospital deductible for each elective non-contract hospital admission.
3. Any penalties for not using Blue Shield (the Utilization Review Organization).
4. Any expenses for services related to: chiropractic care, acupuncture, foot care, hearing aids, and vision therapy.
5. Any dental, vision, or prescription drug expenses.
6. Any expenses which are not eligible expenses under the Plan.
7. See 'Other Covered Expenses' described on page 57. Charges relating to **non-PPO providers** for the services listed do not count toward the out-of-pocket maximum.

Once the out-of-pocket maximum is reached, the Plan pays all of your eligible dependents' additional eligible expenses for the rest of the year.

Important
Cost Containment Information

PREAUTHORIZATION GUIDELINES

The following is a summary of all benefits that require preauthorization. Please review the preauthorization guidelines carefully, as failure to obtain preauthorization could result in reduced or denied benefits.

1. INPATIENT HOSPITAL
   Call Blue Shield at 1-800-541-6652.

2. OUTPATIENT HOSPITAL
   Call Blue Shield at 1-800-541-6652.

3. OTHER COVERED SERVICES:
   - Anything the Trust Fund Office deems necessary. This certification will be required after the treatment or procedure is provided but before the claim is paid, and will be pursued by the Trust Fund Office.
   - Hospice Care (for any extension beyond 6 months)
   - Skilled Nursing Facility
   - Organ Transplants

   Call Blue Shield at 800-541-6652.

4. ALCOHOL AND SUBSTANCE ABUSE SERVICES:
   (A) Detoxification: Call Blue Shield at 1-800-541-6652.
   (B) Other alcohol and substance abuse benefits: Call Beat It! at 1-800-828-3939.

5. GASTRIC BYPASS SURGERY:
   Call Blue Shield at 1-800-541-6652.

UTILIZATION REVIEW PROGRAM

The Indemnity Program requires **Pre-Admission/Concurrent Utilization Review (UR) for every hospitalization.** The purpose of UR is to ensure that the hospital admission is medically necessary and the length of stay is appropriate. The UR program also helps avoid hospitalization when another form of care may be equally effective, and may prevent a surgical procedure that is not covered by the Plan. Often, there is more than one way to treat a particular condition. When this is the case, the Plan pays up to the UCR amount for the least expensive but appropriate service. UR can also save you and the Plan money.

HOW TO USE THE UTILIZATION REVIEW PROGRAM

It is your responsibility to obtain Certification of Medical Necessity, or authorization, by calling Blue Shield within the required time frames for any of the following medical treatments. You may also have the doctor, a relative, a friend, or any other person call Blue Shield on your behalf. If UR requirements are not met, you will pay more for that medical care.

The individual who calls should have the following information on hand:

1. The name and social security number of the participant;
2. The name of the Plan;
3. The name and phone number of the attending doctor;
4. The name of the covered facility where the participant will be admitted, if applicable;
5. The proposed date of admission, if applicable; and
6. The proposed treatment.

A Blue Shield authorization does not verify a participant's eligibility for coverage under the Plan; nor is it a guarantee that benefits will be paid for a proposed treatment. All benefits are subject to eligibility requirements, covered medical charges, and all other provisions and limitations of the Plan. Certification in no way limits freedom of choice or releases the attending Physician from patient care responsibility.

It is your responsibility to contact Blue Shield at 1-800-541-6652.

INPATIENT REVIEW PROGRAM

1. You or your representative must contact Blue Shield at least 3 business days prior to any scheduled, non-emergency hospital admission. If Blue Shield approves the proposed treatment, it will advise the doctor or the hospital of its decision, and assign an initial length of stay.
2. If you have less than 3 business days prior to a scheduled admission, or you are admitted for Emergency Care, you or your representative must call Blue Shield within 48 hours after such urgent or Emergency admission.

Once you are hospitalized, Blue Shield will continue to review your situation as long as you stay in the hospital. This process is called concurrent review. At the end of the authorized length of stay, Blue Shield will contact the doctor or hospital to determine if you will be discharged, or if additional days are required. If additional days are required, the doctor or hospital must provide Blue Shield with the supporting data, and Blue Shield will repeat its review process. If Blue Shield approves the extended stay, it will assign an additional length of stay and provide notification.

If a covered participant **fails** to use the Inpatient Review Program:

1. all benefits otherwise payable in connection with the confinement may be reduced by 20%; and

2. benefit payment will be based on the length of stay that would have been authorized if the Utilization Review Program had been used.

No benefits will be paid for any days of confinement which were not authorized. However, if upon appeal and review the Plan finds that the continued stay was Medically Necessary, benefits will be paid in accordance with the terms and conditions of the Plan.

UNAUTHORIZED ADMISSION—Appeal and Review Procedure

If an admission or any part of the confinement is not authorized, Blue Shield will notify you, the doctor or hospital, and the Trust Fund Office of its decision. The notice will be by telephone, followed by a written letter.

With respect to a continued stay, if additional days are not authorized, the letter will advise the last authorized date of confinement. The notice will also advise you of your right to appeal the decision and request a review.

If an admission, or any part of an admission, is not authorized, you can appeal the decision, and may have the Doctor or hospital submit additional information to support the recommendation. Blue Shield will refer the review to a Board-Certified Doctor who was not previously involved with the case.

Whether or not Blue Shield authorizes the proposed treatment, it is the sole right of you and your doctor to decide whether or not to be admitted, or what is the appropriate length of stay in a hospital. However, if Blue Shield has not authorized all or part of the admission, benefits may be reduced or denied.

If Blue Shield is not contacted for inpatient services as specified above, Plan benefits may be reduced by 20%, or denied altogether.

It is your responsibility to contact Blue Shield at 1-800-541-6652.

OUTPATIENT SERVICES REVIEW PROGRAM

The following guidelines are to assist you in determining the need for authorization from Blue Shield ***before*** non-emergency outpatient services are provided:

- Anything the Trust Fund Office deems necessary. This certification will be required after the treatment or procedure is provided but before the claim is paid, and will be pursued by the Trust Fund Office.
- Hospice Care (for any extension beyond 6 months)
- Skilled Nursing Facility
- Organ Transplants

UTILIZATION REVIEW ORGANIZATION FOR OUT-OF-STATE MEMBERS

If you reside out-of-state, the same utilization review guidelines described above apply to you. It is your responsibility to contact Blue Shield at 1-800-541-6652.

PREFERRED PROVIDER NETWORK FOR IN STATE MEMBERS

The Board of Trustees has retained Blue Shield to manage the Sheet Metal Workers Preferred Provider Organization (PPO). This organization negotiates with qualified doctors, hospitals, and laboratories to provide treatment and services at special contract rates to Sheet Metal Workers Local 104 participants and their eligible dependents.

At the discretion of the Trustees, the Plan may pay the PPO percentage of UCR for Non-PPO providers if the participant has to travel more than 100 miles to receive care from a PPO provider. The Trustees, or a committee designated by the Trustees may consider the severity of the illness, the quality of care available and the degree of hardship on the Participant.

HOW TO FIND A PREFERRED DOCTOR OR HOSPITAL

In order to maximize your benefits, you are encouraged to use a preferred provider (doctor or hospital). See page 34 for a summary of the different Plan payments for utilization of PPO providers versus non-PPO providers.

If you have questions about the Preferred Provider Network of doctors, hospitals, or labs presently available in your area, or if you would like the most recent list of providers, contact the Blue Shield website at www.blueshieldca.com/networkppo, or call the Trust Fund Office at 1-800-548-1771 or 1-925-208-9994.

Please be aware that a doctor listed as a PPO physician in the Blue Shield directory may also have practices that are not PPO. When you seek treatment from a physician, please contact Blue Shield before setting up an appointment to confirm that the particular practice is a PPO provider.

PREFERRED PROVIDER NETWORK FOR OUT-OF-STATE MEMBERS

Benefits will be provided for Covered Services received outside of California within the United States, Puerto Rico, and U.S. Virgin Islands. The Sheet Metal Workers Local 104 Health Care Plan calculates the Participant's Copayment either as a percentage of the Allowable Amount or a dollar Copayment, as defined in this SPD. When Covered Services are received in another state, the Participant's Copayment will be based on the local Blue Cross and/or Blue Shield plan's arrangement with its providers. See the BlueCard Program section in this SPD.

Blue Shield of California has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of California, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard Program.

When you access Covered Services outside of California you may obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Plan"). In some instances, you may obtain care from non-participating healthcare providers. The Sheet Metal

Workers Local 104 Health Care Plan's payment practices in both instances are described in this SPD.

If you do not see a Participating Provider through the BlueCard Program, you will have to pay for the entire bill for your medical care and submit a claim form to the local Blue Cross and/or Blue Shield plan or to the Sheet Metal Workers Local 104 Health Care Plan for payment. The Sheet Metal Workers Local 104 Health Care Plan will notify you of its determination within 30 days after receipt of the claim. The Sheet Metal Workers Local 104 Health Care Plan will pay you at the Non-Preferred Provider Benefit level. Remember, your Copayment is higher when you see a Non-Preferred Provider. You will be responsible for paying the entire difference between the amount paid by the Sheet Metal Workers Local 104 Health Care Plan and the amount billed.

Charges for Services which are not covered, and charges by Non-Preferred Providers in excess of the amount covered by the Plan, are the Participant's responsibility and are not included in Copayment calculations.

To receive the maximum Benefits of your Plan, please follow the procedure below.

When you require Covered Services while traveling outside of California:

1. call *BlueCard Access®* at 1-800-810-BLUE (2583) to locate Physicians and Hospitals that participate with the local Blue Cross and/or Blue Shield plan, or go on-line at www.bcbs.com and select the "Find a Doctor or Hospital" tab; and,
2. visit the Participating Physician or Hospital and present your membership card.

The Participating Physician or Hospital will verify your eligibility and coverage information by calling *BlueCard Eligibility* at 1-800-676-BLUE. Once verified and after Services are provided, a claim is submitted electronically and the Participating Physician or Hospital is paid directly. You may be asked to pay for your applicable Copayment and Plan Deductible at the time you receive the service.

You will receive an Explanation of Benefits which will show your payment responsibility. You are responsible for the Copayment and Plan Deductible amounts shown in the Explanation of Benefits.

Prior authorization is required for all Inpatient Hospital Services and notification is required for Inpatient Emergency Services. Prior authorization is required for selected Inpatient and Outpatient Services, supplies and Durable Medical Equipment. To receive prior authorization from the Sheet Metal Workers Local 104 Health Care Plan, the out-of-area provider should call the customer service number noted on the back of your identification card.

If you need Emergency Services, you should seek immediate care from the nearest medical facility. The Benefits of this Plan will be provided for Covered Services received anywhere in the world for emergency care of an illness or injury.

Care for Covered Urgent Care and Emergency Services Outside the United States

Benefits will also be provided for covered urgent and emergent services received outside of the United States, Puerto Rico, and U.S. Virgin Islands. If you need urgent care while out of the country, call the BlueCard Worldwide Service Center at either the toll-free BlueCard Access

number (1-800-810-2583) or collect (1-804-673-1177), 24 hours a day, seven days a week. In an emergency, go directly to the nearest hospital. If your coverage requires precertification or prior authorization, you should also call the Sheet Metal Workers Local 104 Health Care Plan at the customer service number noted on the back of your identification card. For inpatient hospital care, contact the BlueCard Worldwide Service Center to arrange cashless access. If cashless access is arranged, you are responsible for the usual out-of-pocket expenses (non-covered charges, Deductibles, and Copayments). If cashless access is not arranged, you will have to pay the entire bill for your medical care and submit a claim to the BlueCard Worldwide Service Center.

When you receive services from a physician, you will have to pay the doctor and then submit a claim.

Before traveling abroad, call your local Customer Service office for the most current listing of providers world-wide or you can go on-line at www.bcbs.com and select "Find a Doctor or Hospital" and "BlueCard Worldwide."

BlueCard Program

Under the BlueCard® Program, when you obtain Covered Services within the geographic area served by a Host Plan, the Plan will remain responsible for any payment due, excluding the Participant's liability (e.g., Copayment and Plan Deductible amounts shown in the Benefits SPD. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

The BlueCard Program enables you to obtain Covered Services outside of California, as defined, from a healthcare provider participating with a Host Plan, where available. The participating healthcare provider will automatically file a claim for the Covered Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the member copayment and deductible amounts, if any, as stated in this SPD.

Whenever you access Covered Services outside of California and the claim is processed through the BlueCard Program, the amount you pay for Covered Services, if not a flat dollar copayment, is calculated based on the lower of:

1. The billed covered charges for your Covered Services; or
2. The negotiated price that the Host Plan makes available to Blue Shield of California.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Plan pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price the Sheet Metal

Workers Local 104 Health Care Plan uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Plan to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any Covered Services according to applicable law.

Claims for Covered Services are paid based on the Allowable Amount as defined in this SPD.

Special Cases: Value-Based Programs

BlueCard® Program

If you receive covered services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Blue Shield through average pricing or fee schedule adjustments.

Negotiated (non–BlueCard Program) Arrangements

If Blue Shield has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Employer on your behalf, Blue Shield will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

Definitions

Care Coordination: Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Participant's healthcare needs across the continuum of care.

Care Coordinator: An individual within a provider organization who facilitates Care Coordination for patients.

Care Coordinator Fee: A fixed amount paid by a Blue Cross and/or Blue Shield Licensee to providers periodically for Care Coordination under a Value-Based Program.

Negotiated Arrangement: An agreement negotiated between a Control/Home Licensee and one or more Par/Host Licensees for any National Account that is not delivered through the BlueCard Program.

Provider Incentive: An additional amount of compensation paid to a healthcare provider by a Blue Cross and/or Blue Shield Plan, based on the provider's compliance with agreed-upon procedural and/or outcome measures for a particular group of covered persons.

Value-Based Program (VBP): An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.

HOW TO USE THE PREFERRED PROVIDER NETWORK

Each time you need medical care, you may choose any doctor or facility in the Preferred Provider Network. When you use a provider in your area, keep these important points in mind:

1. When you call for an appointment, indicate that your coverage is through the Sheet Metal Workers Local 104 Health Care Plan and you are using the Preferred Provider Network managed by Blue Shield.
2. Fill out a claim form and indicate that the Trust Fund is making a direct payment to the doctor, hospital, or lab. The Trust Fund will process the claim and send you and the provider an Explanation of Benefits. After your claim has been processed, the Trust Fund will inform you of any expenses you must pay.
3. Your Explanation of Benefits will indicate:
   (a) Any eligible expenses you are required to pay the provider.
   (b) Expenses the Sheet Metal Workers Local 104 Plan has paid to the provider.
   (c) The discount amount that the provider has agreed not to charge.
4. Your eligible expenses are at the special contract rate –– not the regular fee charged. You are not responsible for paying the provider's full fees indicated. If the provider accidentally bills you for the full amount, simply send the provider a copy of the Explanation of Benefits.

CONTRACT (PPO) HOSPITALS

When you or an eligible dependent is hospitalized, the Plan benefit depends on whether the hospital is a "contract" or PPO hospital. If you use a PPO hospital, your cost will be less.

When you use a contract hospital, the Plan will pay 80% of the negotiated rate for hospital services **subject to Utilization Review.**

If you do not use a contract hospital, there will be a **$200 deductible** for each elective admission, and the Plan will pay 65% of usual customary and reasonable (UCR) charges, **subject to Utilization Review.**

If you are admitted to a non-contract hospital, and Blue Shield certifies the admission as an emergency or "referral" admission, the Plan will pay 80% of UCR charges, until Blue Shield determines that the patient is stabilized and can safely be transferred to a contract hospital.

A "referral" is an admission to a non-contract hospital when the medically necessary services cannot be rendered in a contract hospital within a 30-mile radius of your residence.

Use of non-contract providers may significantly increase your out-of-pocket costs, and these payments do not count toward your annual out-of-pocket maximum.

OUTPATIENT SURGICAL CENTER

When you or an eligible dependent require outpatient surgery, the Plan benefit depends on whether or not the outpatient surgical center is a contracting facility. When you use a contract surgical center, the Plan will pay 80% of the negotiated contract rate, subject to Utilization Review. When you use a non-PPO facility, the Plan will pay 65% of UCR charges, subject to Utilization Review.

Description of Covered Medical Services

ACUPUNCTURE TREATMENT

The Plan pays 80% of covered expenses, up to a maximum of $60 for each visit and $600 per calendar year, for acupuncture treatment by a licensed acupuncturist, consistent with customary treatment for the patient's illness or injury.

CASE MANAGEMENT/TRANSITIONAL CARE

In some instances, a patient's needs may be met as well or better by offering an alternative to an acute care hospital confinement or other type of care. Such alternatives include home health, hospice, or skilled nursing facility care. In appropriate cases, working with the patient's own physician, the case management program assesses whether an alternative treatment is suitable for the individual patient and helps ensure that the health care services are coordinated and carried out in a manner that ensures continuity and quality of care.

The alternative treatment programs will pay benefits only on expenses incurred for these programs that have been arranged and pre-approved by Blue Shield and are part of the Plan provisions.

The Plan has contracted with Blue Shield to provide Case Management in the transition from an acute hospital stay to one of the following levels of care: Home Health Care, Hospice Care, and Skilled Nursing Care. For more information, call Blue Shield at 1-800-541-6652.

If you are out-of–state, contact Health Care Management at 1-800-333-3018 for Case Management in the transition from an acute hospital stay to one of the following levels of care: Home Health Care, Hospice Care, and Skilled Nursing Care.

HOME HEALTH CARE

Home Health Care is covered, up to 80% of UCR, subject to preauthorization. The Plan pays for up to 30 days of home health care per calendar year.

HOSPICE CARE

Hospice Care services encourage the caregivers and patients to consider palliative care (the treatment to relieve pain or suffering) as an alternative to more aggressive treatment. Hospice care benefits are paid at 80% of UCR, and there must be certification from a physician that the life expectancy is less than six months. Continuation after six months must be approved by Blue Shield. The following inpatient and home care services will be covered:

- daily hospice room and board or care given at the home
- use of medical equipment
- homemaker services

– counseling services

SKILLED NURSING FACILITY

A Skilled Nursing Facility is either a nursing home with skilled nursing care, a convalescent hospital, or a special hospital wing for convalescent patients. **Admission to a Skilled Nursing Facility requires pre-authorization.** The Plan pays benefits at 80% of the negotiated rate and 65% of the non-negotiated rate, provided that Blue Shield certifies medical necessity, up to 100 days per calendar year.

CHIROPRACTIC CARE

The chiropractic benefit is limited to a $1,560 maximum per person each calendar year. The Plan pays up to $60 for each office visit (limited to 1 per day and a maximum of 26 visits per calendar year) and the Plan will cover one full spine x-ray per 6-month period. The initial chiropractic consultation and x-rays are covered the same as any other medical treatment.

COLONOSCOPY OR SIGMOIDOSCOPY EXAMINATIONS

Age 50 or Older

The Plan will cover colonoscopy or sigmoidoscopy examinations received by participants and dependent spouses who are at least 50 years of age. Covered charges will be paid at 100% if services are performed by a PPO provider or 65% of UCR charges if services are performed by a non-PPO provider.

Under Age 50

For Participants with average risk (no problems are found and there is not a family history), colonoscopy examinations will be covered once every 10 years.

For Participants with above-average risk (you or a family member were diagnosed with colorectal cancer or polyps), colonoscopy examinations will be covered once every 2 years.

All examinations falling within the above stated guidelines will be covered at 80% if services are performed by a PPO provider or 65% of UCR charges if services are performed by a non-PPO provider.

Blue Shield does not require prior authorization for diagnostic procedures; however, we urge you to be aware of the costs up front, because they can vary depending on where the test is performed. Generally, a colonoscopy can be performed in an ambulatory surgical center or in a doctor's office. If the test is performed in the hospital, the costs can be much greater. **Be certain that you and your physician know the extent of your coverage before you have the procedure performed.**

DURABLE MEDICAL EQUIPMENT (DME)

The following is paid at 80% of UCR: rental (or purchase, if the cost is less than the rental for the period required) of durable medical equipment such as oxygen, a wheelchair, or hospital bed, for medically necessary therapeutic treatment of a covered illness or non-industrial injury, and which is:

1. Of no further use when medical need ends; and
2. Usable only by the patient; and
3. Not primarily for the comfort or hygiene of the eligible individual, or solely to aid the caregiver; and
4. Not for environmental control; and
5. Not for exercise; and
6. Which is manufactured specifically for medical use; and
7. Approved as effective and usual and customary treatment of a condition as determined by the Plan; and
8. Not for prevention uses.

These expenses do not count toward the out-of-pocket maximum.

GASTRIC BYPASS SURGERY

One gastric bypass surgery per lifetime is covered, payable at 80% of the contract rate, if the following conditions are met:

a. You are diagnosed with morbid obesity; and
b. Gastric bypass surgery is determined to be medically necessary by the Plan's Utilization Review Program; and
c. The surgery is performed in a PPO hospital with PPO providers.

HEARING AIDS

(Indemnity and Kaiser participants)

The Plan pays expenses for hearing aids, when prescribed by a physician or licensed audiologist, at 80% up to $2,000 in benefits for the first aid and $1,000 for the second aid, every 24 months. Rather than purchase a new hearing aid, you can repair your existing aid and the Plan will pay up to the same limit. This benefit applies to both Indemnity and Kaiser Plan participants.

HOSPITAL EXPENSE

When you or your covered dependent is confined to a hospital as a registered bed patient as the result of an injury or illness, the Plan will pay a portion of hospital room and board and miscellaneous hospital expenses (which include items such as the operating room, supplies and drugs used while you are confined, x-rays and lab tests and radiation, physical, speech or occupational therapy) as follows:

1. If you use a contract (PPO) hospital, the Plan will pay 80% of the negotiated rate for hospital services (this includes both room and board and miscellaneous hospital charges, subject to Utilization Review (UR) through Blue Shield).

   The charges you are liable for on a contract hospital's inpatient bill include charges for non-covered items, such as television.

   If the UR Program is not used, Plan benefits may be reduced by 20%, or denied altogether.

   Routine newborn charges at contract hospitals are included with the mother's negotiated rate.

2. If you use a non-contract hospital, the Plan will pay hospital room and board and miscellaneous hospital charges at a rate of 65% of UCR—AND there will be a $200 per person hospital deductible for each non-emergency and non-urgent admission, subject to Utilization Review. Remember, **if the UR Program is not used, Plan benefits may be reduced by 20%, or denied altogether.**

   Coverage for hospital charges is based on the average semi-private room rate (90% of the lowest priced private room where there are no semi-private rooms).

   Charges for isolation are payable as Intensive Care.

   Emergency admissions are treated and payable as contract hospital admissions. However, the Plan will not continue to pay at the contract hospital benefit rate, in a non-contract hospital, once emergency services are no longer being provided and the patient is stabilized and can be transferred to a contract hospital.

3. Each time you are discharged from the hospital for more than 24 hours, the next hospitalization will be considered a new one.

LABORATORY AND RADIOLOGY

Charges for diagnosis or treatment by a radiologist or laboratory are paid at 80% of the contract rate, if you use a preferred provider. Non-preferred providers are paid at 65% of UCR charges.

For participants who receive services from a non-contract hospital because they are 30 or more miles away from a preferred provider, coverage is paid at 80% of UCR for actives and retirees, up to $130 per calendar year.

NEWBORN'S AND MOTHER'S PROTECTION ACT

Charges by a physician for newborn children while the mother is hospitalized following birth are covered up to 80% of the contract rate for a PPO provider, and up to 65% of UCR charges. The Indemnity Plan guarantees that:

(a) The length of hospital stays for newborn children and their mothers following a vaginal delivery will be at least 48 hours.
(b) The length of hospital stays for newborn children and their mothers following a cesarean section will be at least 96 hours.

Limitations: Generally, federal law does not prohibit the attending provider of a mother or newborn, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). Furthermore, the Plan does not require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTE: You must complete an enrollment from to enroll your child in the Plan.

ORGAN TRANSPLANTS

Allowable Expenses incurred for a Covered Transplant Procedure during an eligible Employee's or Dependent's Transplant Benefit Period will be payable provided that:

A. The recipient must obtain prior approval from Blue Shield for certification of medical necessity and that the procedure is not considered experimental under the terms of the Plan;

B. The recipient does not suffer from a terminal illness and is reasonably expected to live at least one or more years beyond the transplant date;

C. The recipient has the transplant performed at a PPO facility (or Center of Excellence) approved by Blue Shield, and the physicians and surgeons are approved by Blue Shield;

D. Coverage for the organ transplant and related expenses is limited to claims incurred up to 12 months after the date of transplant, for procedures approved and certified by Blue Shield as medically necessary.

I. DEFINITIONS:

Covered Transplant Procedure –- shall mean any one of the following human to human organ or tissue transplants performed during a Benefit Transplant Period:

(a) Bone Marrow	(d) Liver	(g) Kidney	(j) Stem Cell Transplant
(b) Heart	(e) Lung	(h) Pancreas	
(c) Heart/Lung	(f) Liver/Kidney	(i) Cornea	

No other transplants are covered. Experimental procedures for those transplants listed are **not** covered. An Employee or dependent is entitled to one Covered Transplant Procedure per lifetime regardless of whether there has been an interruption in service.

Transplant Benefit Period –- shall mean the period that begins on the later of (a) the date of the Employee or Dependent's effective date of coverage under this Plan or (b) the date of the onset of the covered illness or injury requiring the transplant and ends 12 months after the date the Covered Transplant Procedure is performed.

Recipient –- shall mean an Employee or Dependent covered by this Plan who meets the eligibility requirements set forth above.

Allowable Expenses –- shall mean those expressly set forth herein that are directly related to the Covered Transplant Procedure and the benefit amounts provided therefore, except the amounts payable by the Fund shall not, in any event, exceed the Usual, Customary and Reasonable charge determined by the Board of Trustees in its sole discretion.

Stem Cell Transplant — Stem Cell Transplants for the treatment of AL (Amyloid Light-Chain) amyloidosis will be covered up to a maximum benefit of $175,000, provided only

two organ systems are involved and there is insignificant cardiac involvement. The Experimental or Investigative Services Exclusion does not apply to this benefit.

II. ALLOWABLE EXPENSES:

The Fund will reimburse the following Allowable Expenses incurred as the result of a covered Transplant Procedure during an Employee's or Dependent's Transplant Benefit Period:

(a) Transportation of recipient and a companion to and from the site of the transplant. If recipient is a minor, transportation for two persons who travel with the minor will be covered. Reasonable and necessary lodging and meal costs incurred in the interim by such companions are included, except there is a daily limit of $200 for all lodging and meal costs. Total payment for all transportation, lodging and meal costs for all persons for the Covered Transplant Procedure shall not exceed $5,000.

(b) Hospital room and board, and medical supplies.

(c) Diagnosis, treatment and surgery by a Doctor.

(d) Nursing care by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.).

(e) Rental of wheelchairs, hospital-type beds and other mechanical equipment required to treat respiratory impairment.

(f) Local ambulance service, medication, x-rays and other diagnostic services, lab tests, oxygen.

(g) Rehabilitation Therapy, including speech therapy (not for voice framing or a lisp), audio therapy, visual therapy, occupational therapy, and physiotherapy.

(h) Surgical dressings and supplies.

III. EXCLUSIONS:

No benefits will be payable by the Plan for the following:

(a) Animal and/or mechanical organs except pumps and valves.

(b) Any expense incurred for which the participant would not legally have to pay if there was no coverage for benefits.

(c) Custodial care.

(d) If an Employee or Dependent establishes a Benefit Transplant Period and subsequently loses coverage under the Plan, all benefit payments cease at the time coverage terminates.

(e) Any organ or tissue transplant required as the result of an accidental injury or illness that is not covered by the Plan.

(f) Current Plan rules exclude coverage for organ donors and any related expenses such as donor search and organ procurement fees.

PSYCHIATRIC CARE (Inpatient and Outpatient)

The Plan pays for treatment of mental illness or functional mental disorders when provided by a Doctor of Medicine (M.D.), or a licensed psychologist; or with a physician referral and supervision by the M.D., a Master of Social Work, or licensed family marriage counselor.

INPATIENT PSYCHIATRIC CARE

The Plan pays up to 80% of the contract rate for PPO providers. Non-preferred providers are paid at 65% of UCR charges.

Partial Hospitalization/Day Treatment. The partial hospitalization/day treatment level of care is an alternative to acute inpatient psychiatric care. Patients in this setting require an intensive treatment structure for 4 to 8 hours per day but are able to return to a supportive home environment at night. This benefit is subject to UR by Blue Shield and is in lieu of an inpatient hospital stay.

OUTPATIENT PSYCHIATRIC CARE

The Plan pays up to 80% of the contract rate for PPO providers. Non-preferred providers are paid at 65% of UCR charges.

Charges for psychological testing to determine the diagnosis and extent of a mental disorder are included in this benefit. Biofeedback is considered a mental treatment and is covered if done by a qualified physician as defined by the Plan.

Emergency care, as defined by the Plan, provided by a Non-PPO provider will be paid at the PPO rate, until the patient can be transferred to treatment with a PPO provider.

See page 107 for the definition of mental disease or disorder.

ROUTINE PHYSICAL EXAM

To encourage preventative health care, the Plan pays for routine physical examinations (including sports physicals) provided by a doctor of medicine or doctor of osteopathy, including gynecological examination, mammograms, prostate exams, PSA (Prostate Specific Antigen) and, if required, electro-cardiograms.

This Plan covers all Preventive Services, as defined in the Patient Protection and Affordable Care Act, at 100% with no deducible. The list of Preventive Services changes periodically. You may find a list of services covered as Preventive Services at https://www.healthcare.gov/preventive-care-benefits/.

Effective as of October 1, 2011, the Plan provides coverage for the following items and services at 100% of covered charges at a PPO facility (no copayment, coinsurance or deductible shall apply to these items and services):

- Evidence-based items or services that have in effect a rate of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved;
- Immunizations for routine use in children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
- Certain Preventative care and screening for infants, children and adolescents, as set forth in guidelines supported by the Health Resources and Services Administration (HRSA);
- Other preventative care and screenings for women in guidelines supported by the HRSA, including:

Well-woman visits. Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care (several visits may be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs, and other risk factors). The well-woman visit should, where appropriate, include other preventive services listed in the HRSA guidelines.

Screening for gestational diabetes. In pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes

Human papillomavirus testing. High-risk human papillomavirus DNA testing in women with normal cytology results. Screening should begin at 30 years of age and should occur no more frequently than every 3 years.

Counseling for sexually transmitted infections. Annual counseling on sexually transmitted infections for all sexually active women.

Counseling and screening for human immune-deficiency virus. Annual counseling and screening for human immune-deficiency virus infection for all sexually active women

Contraceptive methods and counseling. All food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity as prescribed.

Breastfeeding support, supplies, and counseling. Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment in conjunction with each birth.

Screening and counseling for interpersonal domestic violence. Annual screening and counseling for interpersonal and domestic violence.

Non-preferred providers are paid up to 65% of UCR charges for the items and services described above.

ROUTINE PODIATRY (FOOT) CARE

The Plan pays 80% up to $600 in benefits per calendar year. Covered benefits include an exam, the excision of corns and calluses, and the developing and fitting of devices to activate or supplement a weakened or atrophied foot. (However, only custom-made appliances are covered, not "off-the-shelf" appliances.) Services must be provided by an M.D., D.P.M., or D.O. for benefits to be covered.

SPEECH THERAPY

The services of a Registered Speech Therapist are paid at 80% of UCR for 30 visits per calendar year, and must be recommended by a qualified physician, as defined in the Plan, who continues to control and direct the overall treatment of the case. In addition, there must be an expectation that the therapy will result in a significant improvement of the specific defect. Prior authorization is required for coverage of any additional visits. Please contact the Fund Office for assistance.

Services will also be covered if:

(a) The services of a speech therapist are required to restore normal speech which was impaired or lost due to illness or non-occupational injury, such as following a stroke or laryngectomy (not for a congenital condition such as mental retardation, or cleft palate), or

(b) The services of a speech therapist are required due to developmental delays such as autism. Services will be provided at 80% of UCR.

SURGEON'S, PHYSICIAN'S AND ANESTHESIOLOGIST'S FEES

Surgeon's fees and physician's fees are paid at 80% of the contract rate, if a preferred provider is used. Surgeons, physicians, and assistant surgeons are paid at 80% of UCR if the services were rendered in an emergency, as defined on page 96, regardless of whether the provider or hospital was PPO or non-PPO. The fees of an anesthesiologist and an assistant surgeon are paid at 80% of UCR regardless of whether they are PPO or non-PPO providers, as long as the surgeon and hospital are PPO providers. The Plan will pay for services of a surgeon and assistant surgeon up to 80% of UCR, regardless of whether the provider or hospital is PPO or non-PPO, *if the services are deemed an emergency as defined by the Plan*. The services of a Registered Nurse as First Assistant (R.F.N.A.) are paid at up to 10% of the surgeon's fees, subject to UCR. The services of a Physician Assistant (P.A.) will be covered if determined to be medically necessary up to 65% of what would normally be paid to an assistant surgeon, subject to UCR.

Fees charged by surgeons and physicians who are non-PPO are paid at 65% of UCR charges, unless the services are performed in an emergency as certified by Blue Shield in which case is paid at 80% UCR.

VISION THERAPY

The lifetime maximum benefit for vision therapy is $600.

Vision therapy, if medically necessary, is covered at 80% up to $25 per visit.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Reconstructive breast surgery expenses incurred by a covered person as the result of a mastectomy on one or both breasts, and in a manner determined in consultation between the attending physician and the patient, are covered as shown below. Any exclusion of benefits for cosmetic surgery does not apply to this benefit. This coverage is subject to the Plan's annual deductibles and coinsurance provisions.

1. Reconstruction of the breast on which the mastectomy has been performed.
2. Surgery on and reconstruction of the non-diseased breast to produce symmetry between the breasts.
3. Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

CORONAVIRUS/COVID-19 TESTING

Until the end of the Public Health Emergency declared by the Secretary of Health and Human Services, the Plan provides coverage for Coronavirus/COVID-19 testing with no cost-sharing (copayments and annual deductible waived), prior authorization or other medical management requirements for both PPO and Non-PPO providers. This includes the test, administration of the test, and the health care provider visit (office visit, telehealth visit, urgent care visit, or emergency room visit) that results in an order for or administration of the test.

PPO Providers will be reimbursed at the negotiated rate. Non-PPO providers will be reimbursed in the amount equal to the cash price for such service as listed by the provider on a public internet website.

TELADOC SERVICES

The Plan provides access to Blue Shield's Teladoc program. Teladoc provides 24/7 access to virtual doctor visits by phone, video, or mobile app. No co-payment is charged for Teladoc visits.

You can register for Teladoc by visiting teladoc.com and completing the required information. You can also call Teladoc at 1-800-Teladoc (835-2362) for assistance.

OTHER COVERED EXPENSES

The following items are paid at 80% of contract rate (if PPO), or UCR charges (if non-PPO) as defined by the Plan. Non-PPO charges will **not** count toward the out-of-pocket maximum.

1. **Artificial limbs and artificial eyes**—including their fitting, to replace any natural limbs and eyes.

2. **Blood**—charges for blood, blood plasma and non-replaced blood. This includes autologous blood, up to $250 per scheduled surgical procedure.

3. **Infertility**—diagnosis to determine the cause of infertility. Treatment of infertility (such as in-vitro fertilization or artificial insemination) is not covered.

4. **Injectables**—Medically necessary antigens and other therapeutic drugs administered by injection by a physician.

5. **Medical supplies**—such as casts, splints, and dressings.

6. **Penile Implants**—are covered when medically necessary and are subject to pre-approval by Blue Shield.

7. **Physical Therapy/Occupational Therapy**—services of a Registered Physical Therapist or Occupational Therapist are covered, up to 20 visits per calendar year. Any visits over 20 must be pre-certified by UR.

8. **Strabismus Surgery**—subject to pre-approval by UR, covered for all ages.

9. **Vasectomies and Tubal Ligations**—are covered.

For PPO providers the following items are paid at 100% of the contract rate. For non-PPO providers the following items are paid at 100% UCR as determined by the Plan. Non-PPO charges will **not** count toward the out-of-pocket maximum.

1. **Ambulance services**—subject to the guidelines supported by the HRSA, professional ambulance transportation required to the nearest hospital equipped to provide the necessary service. Charges for air ambulance are covered where it is cost effective or necessary to avoid the possibility of serious complications or loss of life as determined by the Plan. Charges for air ambulance do **not** count toward the out-of-pocket maximum.

Medical Plan Exclusions

The following expenses will not be paid by the Plan, nor will they count toward your deductible or out-of-pocket maximum:

1. Voluntary **abortions**.

2. Charges for hospital stays, services and supplies you receive before you become **covered** by the Plan, or after your coverage ends.

3. Any goal-oriented **behavior modification therapy**.

4. Rental or purchase of ramps, elevators, stair lifts, pools, spas, hot tubs and filtering systems, saunas, and car hand controls. Air purifiers, air conditioners, humidifiers, exercise equipment, and supplies for **comfort, hygiene, or beautification**, or modification to your home, property or vehicle, regardless of their therapeutic or ease of access value.

5. **Cosmetic surgery**, except for correction of congenital malformation. However, complications resulting from prior cosmetic surgery are covered but not further cosmetic repair work.

6. **Custodial care**. The term "custodial care" means any type of care, which is designed primarily to assist an individual in meeting his or her activities of daily living.

7. **Educational** or occupational testing.

8. Charges which are not **eligible expenses**; however, the Plan reserves the right to waive certain Plan benefit limitations in order to cover more cost-effective care that would otherwise not be considered an eligible expense.

9. **Experimental or Investigative Services**—Experimental services which are defined as those drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans are not covered by the Plan.

10. Expenses related to any **false or fraudulent information** provided to the Plan regarding such things as the name of the patient or provider, the services or treatment provided, the amount of charges, or other related information.

11. Charges for any injury you receive while committing or attempting to commit a **felony** or any consequential illegal activity, except if the injury arises out of acts of domestic violence. The Trustees may waive this provision based on certain facts and/or circumstances.

12. Any claim for medical treatment or services and/or supplies which is not **filed within 12 months** from the later of the date the expense is incurred or the date of payment under another Plan which is primary. Any exceptions to the foregoing will be determined solely by the Board of Trustees.

13. Routine **foot care,** except as provided for on page 55, "excluded foot care" would include "off-the-shelf" products such as shoe inserts, and manipulative procedures on the foot.
14. **Gamma globulin** injections as a preventive (prophylactic) measure.

15. **Genetic testing and counseling**, except if such test is determined to be medically necessary.

16. Any hospital or medical services furnished by a hospital or facility operated by the United States **Government** or any authorized agency thereof, or furnished at the expense of such Government or agency; or provided by any government program or law unless payment is legally required.

    Services, supplies, or treatments for a covered person with a military service-connected disability provided by or covered under any governmental plan or law, or provided by any non-military-connected hospital or institution which does not require the participant to pay for these expenses in the absence of insurance.

    Services, supplies, or treatments provided by an active military hospital or institution or the Veteran's Administration other than: (a) care provided to a veteran for a non-military service-connected disability, or (b) inpatient military hospital care for a non-service-connected disability which is provided to a retired veteran or the dependents of an active military or retired veteran.

17. **Immunizations** not recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

18. Charges incurred by you or your dependent when **ineligible** under the Plan.

19. Treatment of **infertility**, including artificial insemination and in vitro fertilization (although the resulting pregnancy would be covered). Reversal or attempted reversal of an elective sterilization procedure is not covered.

20. **Lasik** and any other corrective refractive eye surgery.

21. Any injury or sickness for which treatment is not provided or authorized by a **licensed physician, psychologist, or chiropractor.**

22. Services of a **massage therapist**.

23. Treatment, services, or supplies that are determined by the Plan or Blue Shield to *not* be **medically necessary** for the treatment of illness or injury, including charges that could have been provided in a more cost-effective manner without affecting the person's health.

24. Any hospital or medical services covered by the Federal **Medicare** Program, to the extent permitted by law.

25. Treatment for **obesity, weight reduction, or diet control** (except for pre-approved gastric bypass surgery), including but not limited to health club memberships, physical fitness programs, and nutritional counseling and food supplements, with the exception of adults at higher risk for chronic disease or as allowed by the Affordable Care Act.

26. Charges that you would not legally have to pay (or would not be charged for) if you had no medical coverage. In addition, the Plan does not pay benefits when there are no **out-of-pocket expenses** by the covered person, such as services provided by an HMO or on any other pre-paid basis, except that the Plan will reimburse the copayments required of the covered person under the pre-paid plan.

27. **Pre-marital examinations**.

28. Services performed by a person who lives in your home or is **related to you by blood or marriage**.

29. Therapy, supplies or counseling for **sexual dysfunctions** or inadequacies. However, outpatient psychiatric treatment is covered under the medical Plan. Viagra and other sexual dysfunction medications are covered by the Plan.

30. Care or treatment of **teeth or gums**, except as required on account of accidental injury to natural teeth sustained while the individual is covered, if service is performed within 6 months of the accident.

31. Treatment for **Temporomandibular Joint (TMJ) Disorder,** except expenses in connection with TMJ surgery to correct a dysfunction in the temporomandibular joint which has been caused by one of the following:
    (a) Ankylosis
    (b) Fracture perforation of the disc
    (c) Neoplastic invasion (abnormal growth)
    (d) Congenital anomalies that interfere with normal function
    (e) Removal of foreign bodies due to trauma

32. Charges for which a **third party** may be liable or legally responsible. Please see page 89 for more information.

33. Any **transportation**, other than professional ambulance service, except as pre-approved by the Plan.

34. Charges which exceed **usual, customary and reasonable** charges.

35. Any hospital or medical services in connection with an injury or disease resulting from insurrection or **war**, whether declared or not, or any act related to insurrection or war, or participation in any riot.

36. Charges incurred due to an injury or illness arising out of or occurring in the course of any occupation or employment for wage or profit, whether or not the individual is covered by **workers' compensation** insurance. This exclusion does not include follow-up health examinations for an asbestosis-related illness as described in the Workers' Compensation section of this booklet on page 89.

Alcohol and Substance Abuse Benefits

"BEAT IT!" is the name of the drug and alcohol abuse program available to all participants and dependents, including those under the Kaiser Health Plan. "BEAT IT!" provides individualized confidential services for you and your eligible dependents. The Trust Fund Office keeps all medical information of Plan participants strictly confidential. Residential Utility Workers and Maintenance Service Technicians are not eligible for this benefit.

The services the Program offers include arranging the following:

1. Initial consultative visits with you and your eligible dependents, including making transportation arrangements;
2. Inpatient admissions;
3. Introduction to the outpatient program.

During your recovery, a "BEAT IT!" representative will monitor your care to help ensure the quality of the treatment and to assist you with any problems that may arise.

Specifically, the "BEAT IT!" Program provides the following benefits as part of your Health Care Plan:

DETOXIFICATION

Detoxification requires prior authorization from Blue Shield. "BEAT IT!" must be contacted for approval on any treatment extending beyond the period of medically necessary detoxification.

Detoxification is paid under the medical plan and is therefore subject to the same Plan rules as any other hospitalization.

KAISER PARTICIPANTS MUST USE A KAISER FACILITY FOR DETOXIFICATION.

INPATIENT REHABILITATION AND THERAPY

First occurrence covered at 100% of the contract rate.

Subsequent occurrences covered at 80% of the contract rate.

OUTPATIENT TREATMENT

Outpatient treatment by an approved "BEAT IT!" provider is covered at 100% of reasonable and customary charges.

Call "BEAT IT!" any time during the night or day at either 1-408-232-9885 or 1-800-828-3939.

Additional information regarding programs offered through Beat It! can be found on the website at beatiteap.com.

A personal confidential interview will be arranged for you to evaluate your present problem and to discuss the method of recovery that will best suit your particular needs. A mutually convenient meeting place between the patient and the provider can be arranged to protect your anonymity.

Once pre-authorization has been obtained, eligibility will be extended through the completion date of any authorized inpatient treatment program.

ALCOHOL AND SUBSTANCE ABUSE BENEFITS NOT PROVIDED BY "BEAT IT!" PROVIDER

Inpatient Treatment provided Out-Of-Network: The Plan will pay 65% of UCR charges.

Outpatient Treatment provided Out-Of-Network: The Plan will pay 65% of UCR charges.

Emergency care, as defined by the Plan, provided by a Non-PPO provider will be paid at the PPO rate, until the patient can be transferred to treatment with a PPO provider.

If You Become Disabled Due to Alcoholism or Drug Abuse

If you become disabled due to alcoholism or drug abuse, and you are enrolled in the Beat It! program, you will qualify for a disability extension as described on page 17. You will be required to submit proof to the Trust Fund Office that you have enrolled in a course of treatment.

Dental Benefits

Dental benefits are available to you and your eligible dependents through Delta Dental. Residential Utility Workers and Maintenance Service Technicians are not eligible for this benefit.

You and your eligible dependents will be covered under the Delta Dental Plan for all covered dental services and supplies. Benefits of the Plan are only available from the dentists listed in the provider directory. Specialist services are covered when you are referred by your chosen provider. Dental benefits are provided subject to the following provisions:

- The maximum calendar year benefit is $2,500 for an individual and $5,000 for a family.
- The Plan covers two cleanings per year at 100%.
- Basic dental work (restorative, periodontic, endodontic) is covered at 80%.
- Major dental work (prosthodontics, implants, crowns) is covered at 50%.

Call Delta Dental at 1-800-765-6003 for more information.

Orthodontic services are provided as part of the dental benefits provided by Delta Dental, subject to the following provisions:

- Each phase of treatment is subject to a $50 deductible.
- Orthodontic treatment is covered at 50% of UCR fees or the Fee Actually Charged, whichever is less.
- The lifetime maximum benefit for orthodontic treatment is $3,000 per individual.
- Orthodontic benefits are available after 12 months of continuous eligibility.

Prescription Drug Benefits

KAISER HEALTH PLAN PARTICIPANTS

- Participants who elect medical coverage under the Kaiser Health Plan must obtain their prescription drugs (for both medical and dental) from a Kaiser facility under the terms of the Kaiser Health Plan, which includes a $10 co-payment for each generic prescription, and a $30 copayment for each brand prescription.
- Prescription drugs obtained at a Kaiser facility may be purchased up to a 30-day supply.
- More information about Kaiser's prescription drug program can be found in the Evidence of Coverage booklet provided by the Trust Fund Office.

INDEMNITY PLAN PARTICIPANTS

Prescription drug benefits are provided under the WellDyneRx program for Indemnity Health Plan participants.

Medicare Retirees—If you are a Medicare-eligible retiree, you and your other Medicare-eligible family members do not need to enroll in Medicare Part D for prescription drug coverage as long as you are covered under the Health Care Plan. The prescription drug benefits you currently receive under the Sheet Metal Workers Local 104 Health Care Plan are as good as or better than the standard Medicare Part D prescription drug coverage. Enrolling in Part D prescription drug coverage will increase your overall cost without giving you better benefits than the Plan provides, and might actually jeopardize your benefits under the Plan. As long as you have prescription drug coverage under the Plan, you are considered to have "creditable coverage"; therefore, if at some later date you choose to enroll in Medicare Part D, you will not be charged a late penalty for delayed enrollment.

There are three ways you can obtain your prescription drugs under this program:

I. WELLDYNERX RETAIL NETWORK PHARMACY

Prescriptions purchased at a retail pharmacy are limited to a 30-day supply. The following copayments apply:

GENERIC:	Tier 1—$15 copayment
PREFERRED BRAND: (Formulary)	Tier 2—25% of the cost of the prescription (with a minimum $15 copay and a maximum $50 copay, per Rx);
NON-PREFERRED BRAND: (Non-Formulary)	Tier 3—25% of the cost of the prescription (with a minimum $15 copay, per Rx, but no maximum); ***Your copayment does not apply to your annual out-of-pocket maximum.***
SPECIALTY: (Formulary)	Tier 4—20% of the cost of the prescription (with a minimum $15 copay and a maximum $50 copay, per Rx). LIMITED

TO 30 DAY SUPPLY

SPECIALTY: (Non-Formulary)	Tier 4—20% of the cost of the prescription (with a minimum $15 copay, per Rx, but no maximum). LIMITED TO 30 DAY SUPPLY. ***Your copayment does not apply to your annual out-of-pocket maximum.***
BRAND (If Generic avail):	$15 *plus* the entire difference between the Brand price and Generic price. ***Your copayment does not apply to your annual out-of-pocket maximum.***

WellDyneRx Network Pharmacy — The WellDyneRx is for those who need immediate, short-term prescription medications and medication that cannot be shipped through the mail.

You do not have to file claim forms. The copayments apply to each prescription filled (up to a maximum supply of 30 days per copayment).

ID Cards — Be sure to show your Sheet Metal Workers Local 104 Prescription Drug Program ID Card to the pharmacist each time you purchase prescriptions at an WellDyneRx Retail Network Pharmacy. The pharmacist uses your ID card and to verify that you are eligible for prescription drug benefits. If you or your eligible family members need additional Prescription Drug ID cards, call the Trust Fund Office at 1-800-548-1771.

Most of the major chain retail pharmacies in California participate in the WellDyneRx Retail Network Pharmacies. Additional participating pharmacy information may be obtained by visiting you WellView Member Portal, the WellDyneRx website at www.WellDyneRx, or by calling the WellDyneRx Members Service Representatives at 1-888-479-2000. If the pharmacist dispensing your prescription(s) requires assistance in submitting your claim to WellDyneRx, they may also call the Members Service Representatives. If you or your dependents utilize your spouse's drug plan, contact the Trust Fund Office and they will send you a Direct Member Reimbursement (DMR) Form. You can then submit the DMR Form for reimbursement of the copay.

II. WELLDYNERX MAIL ORDER PHARMACY

Prescriptions purchased through the Mail Order Service are limited to a 90-day supply; however, if you need long-term maintenance medication, your doctor can write a prescription for up to a 12-month supply. You can obtain up to a 90-day supply of maintenance medication and order 90-day refills as you need them. The copayments are:

GENERIC:	Tier 1—$30 copayment
PREFERRED BRAND: (Formulary)	Tier 2—50% of the cost of a 30-day supply (with a minimum $30 copay and a maximum $100 copay, per Rx);
NON-PREFERRED BRAND: (Non-Formulary)	Tier 3—50% of the cost of a 30-day supply (with a minimum $30 copay, per Rx, but no maximum); ***Your copayment does not apply to your annual out-of-pocket maximum.***

SPECIALTY: (Formulary)	Tier 4—20% of the cost of the prescription (with a minimum $15 copay and a maximum $50 copay, per Rx). LIMITED TO 30 DAY SUPPLY
SPECIALTY: (Non-Formulary)	Tier 4—20% of the cost of the prescription (with a minimum $15 copay, per Rx, but no maximum). LIMITED TO 30 DAY SUPPLY. ***Your copayment does not apply to your annual out-of-pocket maximum.***
BRAND (If Generic avail):	$30 *plus* the entire difference between the Brand price and Generic price. ***Your copayment does not apply to your annual out-of-pocket maximum.***

WellDyneRx Mail Order Pharmacy — You can use this service to order long-term maintenance medication (generic or brand name). Your doctor can prescribe up to a 12-month supply, although no more than a 90-day supply will be mailed at one time. Copayments apply to each prescription filled (up to a maximum supply of 90 days per copayment).

You can register for Mail Order Pharmacy using the WellView Member Portal by registering at www.WellDyneRx.com. Click "Members" then "Register Now." Alternatively, you may complete and mail the Mail Order Pharmacy Registration Form to WellDyneRx.

Sending Prescriptions – You can have prescriptions prescribed by your doctor for 90 day or more filled by the Mail Order Pharmacy, assuming you remain eligible for benefits under the Plan. There are three ways to send your prescription to the Mail Order Pharmacy:

1. Electronically: The quickest way to fill your prescription is to ask your doctor to send it electronically to the WellDyneRx Mail Order Pharmacy.

2. By Fax: Your doctor can fax your prescription to 1-888-830-3608 or 1-877-221-1259.

3. By Mail: Mail the original prescription with your Member ID and the patient's date of birth to WellDyneRx.

Mailing Address: WellDyneRx
P.O. Box 90369
Lakeland, FL 33804

Ordering Refills — You can order refills prescribed by your doctor, assuming you remain eligible for benefits under the Plan. There are three easy ways to refill your prescriptions:

1. Online: Order refills at www.WellDyneRx.com
2. By Mail: Mail the original prescription with your Member ID and the patient's date of birth to WellDyneRx.

Mailing Address: WellDyneRx
P.O. Box 90369
Lakeland, FL 33804

3. By Phone: Order through the WellDyneRx automated phone system by calling the Member Services phone number on your ID Card, press 2 and follow the prompts for mail order information. To access your account, you will be prompted to enter your date of birth, zip code and phone number.

Immediate Purchases — If you need a maintenance medication right away, have your doctor complete two prescriptions — one that can be filled immediately at your pharmacy for a 30-day supply, and the other that can be submitted to the WellDyneRx Mail Order Pharmacy for up to a 12-month supply of medication. You should not submit the 12-month prescription until you and your doctor are sure you can tolerate the medication.

III. NON-NETWORK PHARMACY

Non-Network Pharmacy — When you use a pharmacy that does not participate in the WellDyneRx Network, you pay the full price and then submit a claim to WellDyneRx. You will need your original receipt and the WellDyneRx Claim Form (forms are available from WellDyneRx and the Trust Fund Office). The Plan pays up to the amount WellDyneRx would have paid for the same drug at a WellDyneRx Network Pharmacy, less the applicable copayment amount.

FORMULARY (PREFERRED) DRUGS

Certain brand name prescription drugs are included in the WellDyneRx formulary. A formulary is a list of brand name prescription medications that have been chosen because of their ability to be both clinically and cost effective. The drugs selected for the formulary have been carefully reviewed by a team of medical professionals and must meet high standards for quality and effectiveness.

When you visit your doctor, it is a good idea to bring the WellDyneRx formulary listing with you. For a complete and up-to-date listing of the medications on WellDyneRx formulary, you can use your WellView Member Portal, the WellConnect digital tool, or by calling WellDyneRx Member Service Representatives at 888-479-2000. Ask your doctor to consider using brand name drugs listed on the formulary—or generic substitutes when possible (all of the drugs listed on the formulary are brand name drugs). This will help control Plan costs and maintain high quality for all Plan participants. Using the formulary does not change the way benefits are paid under the Plan. **In addition, some medications on the formulary may not be covered under this Plan**. However, it is recommended that you utilize the prescriptions on the formulary labeled as 'Tier 1' or 'Tier 2' for maximum cost savings for you and the Plan. The prescriptions labeled 'Tier 3' are non-preferred brand drugs that will produce the least cost savings.

WellDyneRx may require that you try certain prescription drugs to treat your condition before covering another drug to treat your condition, this is called "Step Therapy." For example, if both Drug A and Drug B treat your medical condition, WellDyneRx may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Drug B will then be covered. If a prescription drug requires Step Therapy it will be indicated on the WellDyneRx formulary listing.

For new medications prescribed on or after April 1, 2020, the Plan will be utilizing WellDyne's Non-Essential Drug program. Prescription drugs that are considered Non-Essential Drugs by WellDyneRx will no longer be covered by the Plan. Instead, when you or a dependent are prescribed a Non-Essential Drug you will be notified and provided with a list of safe, effective, lower cost alternatives with equivalent therapeutic value. For a list of Non-Essential Drugs, please contact WellDyneRx.

SPECIALTY PHARMACY PROGRAM

There are certain medications that provide complex and costly therapies that require special storage and handling requirements. These include costly injectable therapies and select chemotherapeutic therapies. Specialty medications also include high-cost injectable medications like those used for Multiple Sclerosis, Rheumatoid Arthritis, and Hepatitis C. Specialty medications do not include those used for diabetes or low-cost injectable medications. Many times these medications are not available at your local drug store. WellDyneRx offers a specialty drug program, to provide these medications. These medications are shipped directly to your house or location of choice with the added benefit of comprehensive coverage coordination with WellDyneRx to ensure the lowest possible out-of-pocket expenses.

If you are taking a specialty medication, you will be able to obtain your first fill from a retail pharmacy. After that, all fills must go through the WellDyneRx specialty drug pharmacy. WellDyneRx will call you when it is time for a refill. Specialty prescriptions are limited to a 30-day supply.

To get started, ask your doctor to send your prescription to US Specialty Care electronically at www.USSpecialtyCare.com or by fax to 800-530-8589. Your doctor can also speak with our experienced team of pharmacists by calling 800-641-8475. Your Patient Care Advocate will contact you to help you enroll in our specialty pharmacy program, schedule your medication delivery, and help you manage your medical supplies.

DIABETIC GLUCOMETER

If you or your eligible dependent is diabetic, WellDyneRx has a program available to members at no charge that allows them to receive an OneTouch glucose meter, at no cost. WellDyneRx will send eligible individuals' information about how to take advantage of this program. There is a limit to one glucose meter per individual. You may also be eligible to receive OneTouch Ultra Blue and OneTouch Verio Test Strips at a lower copay through WellDyneRx. Please contact WellDyneRx Member Services at 888-479-2000 with questions.

PRESCRIPTION DRUG EXPENSES COVERED BY THE PLAN

Eligible prescription drug expenses covered by the Plan include charges for outpatient prescription drugs that are:

1. Covered by the Plan,
2. Obtained with a prescription from a licensed doctor,
3. Within WellDyneRx's usual, customary and reasonable limits, and
4. Medically necessary.

Eligible expenses for a single prescription are limited to a 30-day supply at retail and a 90 day-supply from the Mail Order Program. Long-term and maintenance medications determined to be medically necessary by your doctor are also eligible expenses.

Specific expenses covered by the Plan include eligible charges for compounded dermatological preparations, such as ointments and lotions; oral contraceptives; and insulin, diabetic supplies, and ostomy bags and devices. For more information on what specific medications are covered by the Plan, call WellDyneRx at 888-479-2000.

Coordination of Benefits with Other Health Care Plans. You may be reimbursed the amount of any copayment for medication obtained through your spouse's and/or eligible dependent's prescription insurance plan, or paid by Medicare, as secondary insurance, by completing a claim form and submitting it to WellDyneRx.

PRESCRIPTION DRUG EXPENSES *NOT* COVERED BY THE PLAN

The Plan does not cover the following:

1. Prescription drug expenses which are not medically necessary, prescribed by a doctor, within the reasonable and customary limits and covered by the Plan.
2. Prescription drugs dispensed by a hospital while you are confined there.
3. Charges for vitamins, dietary supplements, or other drug or nutritional items that may be obtained without a prescription ***except*** insulin, diabetic supplies such as syringes, strips, lancets, and glucose monitors (limited to $100), and ostomy bags and devices.
4. Charges for cosmetics, health and beauty aids, immunization agents, appliances, and non-drug items. Charges for prescription drugs used primarily for cosmetic purposes, including but not limited to Rogaine.
5. Charges for over the counter smoking cessation drugs or patches that are not prescribed by a physician.
6. Experimental or investigative drugs.
7. An unreasonable supply of drugs as determined by WellDyneRx.
8. Expenses which are covered by Workers' Compensation laws or similar laws or which result from an employment-related accident or illness.
9. Drugs paid for by any local, state (except Medi-Cal) or federal government agency, including Medicare.
10. Expenses related to a military service-connected disability.
11. Drugs provided by a hospital or institution for active military personnel or a Veteran's Administration hospital.
12. Expenses that you would not legally have to pay (or would not be charged for) if you had no health care coverage.
13. Drugs needed for an injury you receive while committing or attempting to commit a felony or any illegal activity.
14. Charges resulting from an injury suffered as a result of war or any act of war.
15. Prescriptions drugs prescribed over WellDyneRx's quantity limits unless approved by WellDyneRx.

If you require a prescription drug that is not covered under the Prescription Drug Program, please submit a request in writing to the Trust Fund Office, and they will present your appeal at the next Trust Fund meeting, where a decision will be made regarding your request.

WHERE TO FIND MORE INFORMATION

Call WellDyneRx at 888-479-2000 or visit the website at www.WellDyneRx.com:

- To find out what pharmacies participate in the WellDyneRx Retail Network (near your home or if you are traveling)
- To request claim forms and mail order prescription drug forms. Additional claim forms and mail order forms are also available from the Trust Fund Office.
- To find out which drugs on WellDyneRx's formulary are covered by the Plan
- To request that a pharmacy be added to the WellDyneRx Retail Network

The WellView Member Portal gives you tools and information to manage your prescription benefits online. You can find a network pharmacy, order refills from the Mail Order Pharmacy, calculate copays, and look up drug information. You can register at www.WellDyneRx. Click "Members" then "Register Now."

WellConnect is a secure texting platform with WellDyneRx that delivers health and prescription information right to your mobile phone. It can be used to find the lowest cost medication to treat your condition, and get tips to stay as health as possible. You can sign up at http://your wellconnect.com/welldynerx. Accept the terms and conditions and select "enroll now".

Vision Care Benefits

Vision care benefits are available to you and your eligible dependents through VSP or Kaiser.

Indemnity Medical Plan participants and eligible dependents will be covered under VSP for vision care services. VSP benefits are only available from the doctors listed in the VSP provider directory. Vision exams will be covered at 100% through VSP providers. Materials are not covered; however, discounts are provided with the utilization of the VSP network.

Kaiser Plan participants and eligible dependents must use Kaiser. Vision exams will be covered at 100%.

Death and Accidental Death and Dismemberment Benefits

Death and Accidental Death and Dismemberment (AD&D) benefits are available to you and your covered dependents, except if you are receiving coverage under COBRA. Residential Utility Workers and Maintenance Service Technicians are not eligible for this benefit.

If you are covered by the Plan when you die, the Plan pays death benefits to your beneficiary—the person you named to receive the benefit. The death benefit will also be provided for members on a disability freeze or who are receiving benefits from the Supplemental Health Care Plan when they die.

Application for death benefits must be received by the Trust Fund Office within 12 months of the loss for any benefit to be payable. In a situation where there are multiple beneficiaries, if one beneficiary does not file timely with the Trust Fund Office (within a 12-month period), no benefits are payable to that beneficiary. The appropriate share will be paid to the beneficiaries that have filed the application in a timely manner. A certified copy of the death certificate must be attached with a completed claim form. If you become divorced, then your former spouse is not entitled to any payment of AD&D benefits and any designation of your former spouse as a beneficiary will automatically be revoked as of the effective date listed on the final dissolution decree.

The amount of your coverage depends on factors such as your employment status and your age. **Your beneficiary may be entitled to an additional benefit if you die as the direct result of an accident.** The accidental death benefit does not cover any loss resulting from disease or medical or dental diagnosis or treatment. Refer to the chart below for benefits that apply to you.

Participant's Status	Death Benefit	Accidental Death Benefit
Employee under age 65	$50,000	$10,000
Employee over age 65	$10,000	$10,000
Unemployed employee	$50,000	$10,000
Disabled employee	$50,000	not applicable
Retired employee under age 65	$10,000	$10,000
Retired employee age 65 or over	$4,000	not applicable
Disabled retiree	$4,000	not applicable

If your surviving spouse was covered by the Plan on the date he or she dies, death benefits are available for his or her beneficiary, as shown below:

After the Participant dies, if the surviving spouse dies, death benefits are as follows:

Surviving Spouse's Status	Death Benefit	Accidental Death Benefit
Surviving spouse **under** age 65	$2,000	$2,000
Surviving spouse **over** age 65	1,000	not applicable

DEPENDENT DEATH BENEFITS

The Plan also provides a death benefit to you if your covered spouse or child dies, or to your surviving spouse if his or her covered child dies, except if you are receiving coverage under COBRA. The amount of the benefit depends on factors such as your employment status and your dependent's age. Refer to the chart below for the benefit that applies to you.

If you are covered under the Plan as an active employee, a death benefit will be paid to you as a result of a covered dependent's death as follows:

Dependent's Status	Death Benefit	Accidental Death Benefit
▪ dependent 6 months or older	$8,000	$4,000
▪ dependent under 6 months	$2,000	$2,000

If you are covered under the Plan as an employee, an unemployed employee, a disabled employee, a retiree, or a surviving spouse, a death benefit will be paid to you as a result of a covered dependent's death as follows:

Dependent's Status	Death Benefit	Accidental Death Benefit
▪ dependent 6 months or older	$4,000	$4,000
▪ dependent under 6 months	$2,000	$2,000

If both parents are Plan Participants, each dependent child will be considered a dependent of both for payment of any death benefit and accidental death benefit, if applicable.

EXCLUSIONS

No death benefits will be paid if you or your covered dependent:

- Dies while committing or attempting to commit a felony or other illegal activity, or
- Dies as a result of war, whether declared or undeclared, or insurrection.
- If you and/or your eligible dependents are receiving coverage under CORBA.

In addition, the Plan does not pay benefits if your dependent child is stillborn.

PAYMENT OF YOUR DEATH BENEFIT AND/OR ACCIDENTAL DEATH BENEFIT

The beneficiary you designate on a written form filed with the Board of Trustees receives your death benefit. You may name any person of your choice, or your own estate, to receive the death benefit. However, if you are married when you die and your spouse has not consented, in writing, to the beneficiary designated on the form you have filed, then one half of your Death Benefit will be paid to your surviving spouse and the form you filed will apply only to the other half.

If you have not filed a written designation of beneficiary, or if a person designated dies before you do and you have not named someone else to receive that person's share, then the death benefit will be paid to the first of the following classes of relatives in which a member survives you:

1. Your spouse;
2. Your children, including legally adopted children, stepchildren, and any child for whom you have been appointed guardian by a court;
3. The beneficiary you have designated under the Sheet Metal Workers Pension Plan of Northern California;
4. Your parents;
5. Your brothers and sisters; and
6. Your estate.

PAYMENT OF YOUR COVERED DEPENDENTS' DEATH BENEFITS

You will receive the death benefit if you are living; otherwise the death benefit will be paid to the first surviving class of the following classes of relatives:

1. In the case of a dependent spouse, the spouse's (a) children, (b) brothers and sisters, or (c) executors or administrators.

2. In the case of the death of a dependent child, the child's (a) parent, (b) brothers and sisters, or (c) executors or administrators.

DISMEMBERMENT BENEFITS

You and your covered dependents are eligible for dismemberment benefits only in the event of loss of sight or limb resulting from a non-employment related accident that occurs while covered by the Plan.

The benefit for you and your covered dependents is $4,000 per incident, payable for the loss of one or more hands, feet or sight of an eye resulting from an accident, per incident.

Loss of a hand means the severance of the hand at or above the wrist-joint. Loss of a foot means the severance of the foot at or above the ankle-joint. The loss of an eye means the total and irrevocable loss of eye sight.

TAXABILITY OF DEATH BENEFITS

The death benefit issued from the Sheet Metal Workers Local 104 Health Care Plan is a self-insured taxable benefit paid directly from the assets of the Plan. This benefit is not life insurance. The Small Business Jobs Protection Act of 1996 repealed the IRS code section that allowed beneficiaries to exclude up to $5,000 of uninsured, employer-funded death benefits from their taxable income. The change in law applied to benefits payable with respect to people who died after August 19, 1996.

Instructions to Form 1099 clearly indicate that the Form 1099-R is used to report death benefit payments paid by a qualified or nonqualified plan to an estate, or to another person, who has acquired the right to receive the payments solely because of the employee's death.

Retiree Health Plan

When you retire and are no longer eligible for Active coverage under the Plan, **you must first exhaust your Reserve Hour Bank before electing coverage under the Retiree Health Plan**. Your Reserve Hour Bank is exhausted when the hours remaining in your Hour Bank are less than the hours necessary to provide further eligibility under the Plan.

The Trustees have established the Retiree Health Plan of the Sheet Metal Workers Local 104 Health Care Plan on the basis that the employer contributions for active employees will, if continued, maintain this Plan for retirees. At the present time, eligible retirees pay only part of the cost for Retiree Plan benefits. The cost of retiree benefits is subsidized from employer contributions earned by active employees. The benefits provided by this Plan can be paid only to the extent that the Trust has available adequate resources for those payments. The Trustees have discretion to reduce benefits of this Plan. The Trustees have discretion to reduce or eliminate the subsidy for benefit coverage to the retirees. The Trustees have discretion to reserve the right to use Trust reserves for benefit coverage for active employees or retirees. The retiree coverage is not a vested benefit and while reserves of the Plan are being accumulated to help underwrite this benefit, those reserves may be utilized for other benefits at the discretion of the Trustees.

No participating employer has any liability, directly or indirectly, to provide the benefits established by this Plan beyond the obligation of the participating employer to make contributions as stipulated in the Collective Bargaining Agreement or the Trust Agreement. In the event that at any time the Trust does not have sufficient assets to permit continued payments under this Plan, nothing contained in this Plan or the Trust Agreement shall be construed as obligating any participating employer to make benefit payments or contributions other than the contributions for which the participating employer may be obligated by his or her Collective Bargaining Agreement or Trust Agreement. Likewise, there shall be no liability upon the Trustees, individually or collectively, or upon the contractor, employer associations or local union to provide the benefits established by this Plan if it does not have assets to make such benefit payments or should the Trustees in their discretion utilize Plan assets for benefits other than subsidizing the Retiree Health Plan.

Retiree Plan benefits include medical, dental, prescription drug, vision care, and death and accidental death and dismemberment benefits for you and your eligible dependent(s). Please note that prior benefit schedules 2, 4 and 5 are closed to new retirees. Once a retiree elects a schedule of benefits, changes are not permitted.

You must have continuous coverage under the Active Plan prior to applying for Retiree Coverage in order to qualify, unless you receive a waiver from the Board of Trustees. Residential Utility Workers and Maintenance Service Technicians are not eligible for retiree coverage.

MEDICARE

Medicare benefits are not automatic; you must apply for them in order to be covered. Medicare benefits are available with two part coverage: Part A is free of charge and provides hospital benefits; Part B provides supplemental medical insurance and you are charged a monthly premium. This Plan coordinates benefits with Medicare as if you are covered under both Medicare Part A and Part B. This means you must enroll in Medicare, **for both Part A and Part B**, as soon as you are eligible for Medicare. **If you do not enroll in Medicare (Part A *and* Part B), the Plan will not cover the portion of the expenses that Medicare would have paid. You must notify the Trust Fund Office immediately upon becoming eligible for Medicare. If you have a dependent that is eligible for Medicare, he or she must enroll in both Part A and Part B also.**

> In order to get full protection, you MUST enroll for both Part A **and** Part B of Medicare before you or your dependent becomes eligible for Medicare.

For more details about Medicare, contact your local Social Security Office.

ELIGIBILITY RULES FOR RETIREE PLAN BENEFITS

Retired employees of participating employers who contribute to the Sheet Metal Workers Local 104 Health Care Plan are eligible for benefits under the Retiree Plan. Eligible dependents are described on page 9.

You will be considered a retired employee under the Plan if you meet all of the following requirements:

1. You are age 52 or over.

2. You have "completely retired" from the Sheet Metal Trade. PLEASE NOTE: The effective date of your retirement under the Northern California Sheet Metal Workers Pension Plan shall be the date you have "completely retired" from the Sheet Metal Trade.

   "Completely retired" is defined as:

   - At age 65 or older, you work less than 40 hours per month in any type of job over which the Sheet Metal Workers International Association has jurisdiction (including all government agency work) or in which your employer is a sponsor of the Plan.

   - You do **not** have any periods of "Suspendible Service" as defined below:

     Suspendible Service is work in "Industry Service" (as defined below), which will result in a Pensioner's or Disabled Participant's benefits being suspended. **After an individual's Normal Retirement Date** (the first month after you reach age 65), Suspendible Service occurs in any month in which the individual works 40 or more hours in "Industry Service" as defined below, except that such hours must be in a geographic area covered by the Plan or a related plan.

Industry Service is service performed in California in the same trade or craft in which the participant worked at any time in Covered Service in the Sheet Metal or in a related industry. Industry Service in the Sheet Metal or in a related industry is work in the "Sheet Metal Industry", including all branches of the Sheet Metal trade and the business activities of the types engaged in by the Employers maintaining the Plan. It includes self-employment, working as a manager, supervisor or consultant, or any other Sheet Metal employment. "Industry Service" shall be interpreted in the broadest possible manner.

- Between ages 52 and 65, you perform no work in any type of job over which the Sheet Metal Workers International Association has jurisdiction (including government agency work) or in which your employer is a sponsor of the Plan. However, you will still be considered "completely retired" if you work as a part-time instructor (less than 40 hours per month).

3. You meet the 60/84 test as follows:

   During the 84 months prior to the date you are "completely retired", you had 60 months of active eligibility including any of the following:
   - Hour bank
   - Disability extension
   - Subsidized self-pay
   - Supplemental Health Care (SHC) payments.

   Note: If the date you "completely retire" is deemed to be retroactive, if for example, you get a retroactive Social Security Disability award, the retroactive period will not count toward the 60/84 test, and retiree premiums will be due for the retroactive period, excluding any period of coverage provided by your Hour Bank. The Trustees may waive this provision upon a showing of good cause, determined solely within their discretion.

   If, at the time you retire, you are not eligible for a pension benefit from the Northern California Sheet Metal Workers Pension Plan, the 60/84 test will start effective the first of the month following the month you last worked in covered employment. Your first retiree premium will be due the first of the month following the month you last worked in covered employment, or the first of the month following the month your Hour Bank runs out, whichever is later.

   Any time during which you are on COBRA continuation coverage does not count toward your 60 months.

   Exceptions:
   1992 and 1993: The Plan will disregard calendar years 1992 and 1993 entirely if the following conditions are met:
   - You were signed on the out-of-work list and available for work throughout calendar years 1992 and/or 1993, and
   - You satisfy all retiree eligibility requirements except the 60/84 test, and
   - You failed to meet the 60-month test solely due to severe unemployment during 1992 and 1993.

- The Board of Trustees must review and approve applications for such waivers.

2010 and 2011: The Plan will disregard calendar years 2010 and 2011 entirely if the following conditions are met:

- You were signed on the out-of-work list and available for work throughout calendar years 2010 and/or 2011, and
- You have not refused work covered under the Collective Bargaining Agreement, and
- You have not worked in non-covered sheet metal industry service during 2010 and 2011, and
- You satisfy all retiree eligibility requirements except the 60/84 test, and
- You failed to meet the 60-month test solely due to severe unemployment during 2010 and 2011.
- The Board of Trustees must review and approve applications for such waivers.
- The Board of Trustees may waive the continuous coverage requirement upon showing good cause.

Shipyard Employment: The Plan will allow credit for up to twelve (12) months of employment in the shipyards to be applied to the 60/84 test, under the following conditions:

- Such employment would be recognized for credit towards retirement benefits under the Sheet Metal Workers of Northern California Pension Plan;
- You are not eligible for retiree coverage under the shipyard plan.

4. You maintain your membership in Local 104 of the Sheet Metal Workers International Association.

5. You apply for retiree coverage no later than the date you retire and begin making payments as soon as you are eligible for benefits. Upon application, you may temporarily opt out of the Retiree Health Plan and postpone making payments for you and/or your eligible dependents under the following circumstances. Note that Medicare does not constitute other group coverage for this purpose.

   (a) At Retirement, You are Covered Under Your Spouse's Group Health Plan. At retirement, you may elect to temporarily opt out of the Local 104 Retiree Plan if you are covered under your spouse's group health plan. You must inform this Plan in writing at the time of retirement that you are declining coverage because you are covered under your spouse's plan. Once the other coverage ceases, you may opt back in to the Local 104 Retiree Plan if you can prove you had continuous coverage from the date of your retirement and you begin making payments to this Plan within 30 days of losing the other coverage.

   (b) During Retirement you Marry or Your Spouse Obtains Other Group Coverage. If during your retirement you marry or your spouse obtains other group coverage, you and/or your spouse each have a 'one-time' opportunity to opt out of the Local 104 Retiree Plan. You must inform this Plan in writing at the time you opt out that you are declining coverage because you are covered under your spouse's plan. Once the other coverage ceases, you may opt back into the Local 104 Retiree Plan if you can

prove you had continuous coverage from the date you opted out and you begin making payments to this Plan within 30 days of losing the other coverage.

(c) Your Spouse Declines Coverage because He/She is Enrolled in His/Her Own Group Plan. If at the time of your retirement or the time of marriage, whichever is later, your spouse is enrolled in his/her own group health plan, he/she may decline coverage in the Local 104 Retiree Plan. Your spouse must inform this Plan in writing at the time of declining coverage that he/she is declining coverage because of enrollment in his/her own group health plan. Once the other coverage ceases, he/she may be enrolled into this Plan if he/she can prove he/she had continuous coverage from the date of your retirement or marriage, whichever is later, and you begin making payments to this Plan within 30 days of the date your spouse lost his/her other coverage.

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

7. The Board of Trustees has the discretion to waive any and all of the above criteria.

For information regarding when coverage ends, please refer to page 11.

RETIRED OWNER/MANAGERS

The Plan will determine retiree eligibility for Plan participants who were previously covered as Owner/Managers at the last time the participant was eligible through Owner/Member and/or Collective Bargaining Agreement participation, and extend retiree coverage if the participant would have met the requirement set forth on page 78, item #2, and satisfied the remaining requirements for retiree status at the time of application when the participant was a bargaining employee. Owner/Managers are required to contribute at the unsubsidized rate.

ELIGIBLE DEPENDENTS

Please refer to page 9 for a definition of eligible dependents. Domestic partners of retired employees are not covered under the Retiree Health Plan.

You must enroll your eligible dependents within 90 days of the date you acquire a new dependent, such as through marriage, birth or adoption.

You may remove your dependent child who is under the age of 19 at the end of the calendar year from the Plan if your dependent child is enrolled in a different group health plan or an individual medical policy. You must make your request to remove the dependent child in writing and provide proof of the other medical coverage during Open Enrollment or your enrollment into the Retiree Plan. You may re-enroll the dependent child who is under the age of 19 at the end of the calendar year at Open Enrollment or within 90 days of when the dependent child who is under the age of 19 at the end of the calendar year loses such other health care coverage so long as the child remains an eligible dependent and complete any enrollments forms or any other documents that may be required by the Fund Office. See "Special Enrollment for Dependents" for more information.

RETIREE SUBSIDIZED SELF PAYMENT RATES

Retiree rates are established by the Board of Trustees and may change from time to time. The Trustees have discretion to reduce or eliminate the subsidy.

If you elect to continue coverage as a retiree and you are receiving a pension from the Sheet Metal Workers of Northern California Pension Trust Fund, your payments to this Plan may be deducted from your monthly pension checks.

IF YOU BECOME DISABLED PRIOR TO RETIREMENT

If you are totally or partially disabled as defined below and you meet the eligibility requirements for retired employees above (except the requirement that you be age 52 or older), you can continue Plan coverage as a retiree. You must enroll in Medicare Part A and Part B as soon as you become eligible and provide the Fund Office with a copy of your Medicare card.

To be considered "totally disabled", you must be:

1. Entitled to disability benefits under Social Security, or you would be entitled if you had sufficient quarters of disability, and
2. Unable to engage in any work earning more than the gainful activity level as deemed by Social Security. You must report any income in excess of the gainful activity level to the Trust Fund Office by each July 15 and January 15. This amount is set by Social Security and may change from time to time.

You are considered "partially disabled" if you have a physical or mental condition from an injury, disease or mental disorder, which makes you incapable of working in the sheet metal industry for the remainder of your life.

You must apply for retiree coverage no later than the date you exhaust your reserve Hour Bank. You may postpone commencement of coverage as described in the Retiree Eligibility Rules.

The Trust Fund Office will require you to submit proof of your continuing disability from time to time. If you are under age 52 and you are no longer totally or partially disabled, your coverage will end. However, if you return to work on a trial basis (as allowed by Social Security) you may continue Plan coverage as a retiree until you regain eligibility as an active employee.

IF YOU RETURN TO WORK AFTER RETIREMENT

If you are retired but are thinking of returning to work, you should request an advance decision from the Trustees on whether your proposed employment will adversely affect your eligibility for retiree coverage. Such requests should be made in writing and sent to the Trust Fund Office. If you return to work in the industry in a position not covered by the Collective Bargaining Agreement, except if you work less than 40 hours per month as a part-time instructor for a Joint Apprenticeship Committee in the Sheet Metal Industry, you may continue to participate in the Retiree Health Care Plan at unsubsidized retiree rates. Failure to notify the Trust Fund Office of your return to work will result in termination of your retiree health care coverage.

<u>If You are Age 65 or Older and Work Less Than 40 Hours per Month</u>
If you return to work after retirement, if you are age 65 or older and work less than 40 hours per month in any type of job over which the Sheet Metal Workers International Association has jurisdiction, including all government agency work, or in which your employer is a sponsor of the Plan, you will still be considered a retiree in terms of how you are covered by the Plan. The hours you work will go into your Reserve Hour Bank initially and be stored for use later on.

The following January 1, your status will switch and you will be eligible for benefits under the Plan as an active employee. Then, for as many months as the hours in your Reserve Hour Bank allow, you will be covered under the Plan as an active employee under the schedule of benefits for which contributions were made on your behalf. During this period, you will *not* have to make payments to the Plan since you already have eligibility based on your Reserve Hour Bank. Medicare is secondary on claims you and your covered dependents who are eligible for Medicare incur while you are covered as an active employee.

After your Reserve Hour Bank drops below the minimum required hours, you will revert to retiree coverage status and be covered by the benefits schedule you chose upon retiring. Any remaining hours in your Reserve Hour Bank will be saved for the next year. Medicare is primary on claims you and your covered dependents eligible for Medicare incur while you are covered as a retiree.

<u>If You are Younger than Age 65 or Work More Than 40 Hours per Month</u>
If you return to work before age 65 or you work more than 40 hours per month, you can continue to pay for retiree coverage until you reestablish eligibility as an active employee. Your retiree coverage will be reinstated in accordance with the Suspendible Service rules set forth in the Sheet Metal Workers Pension Plan of Northern California.

Sheet Metal Workers' National Health Fund
2016 Medicare Advantage Prescription Drug Plan Option 1

If you and your eligible spouse are eligible for Medicare, you may elect to participate in the Sheet Metal Workers Nation Health Fund 2016 Medicare Advantage Prescription Drug Plan Option 1 offered through Humana ("Humana") and administered by Southern Benefit Administrators, Inc. You must complete and submit an application in order to be covered under Humana; otherwise, you will automatically transfer to the Indemnity Medical Plan.

Important Humana information you should be aware of:

1. You MUST enroll in Medicare Part A and Part B as soon as you are eligible under Medicare.

2. You MUST continue to pay Social Security for your Medicare Part B coverage.

3. Humana will cover all medically necessary items and services, even if you get the services out of network. However, your member cost share may be lower if you use in-network providers. "In-network" means that your doctor or provider is on our list of participating providers. "Out-of-network" means that you are using someone who isn't on this list. The exception is for emergency care or urgently needed services. This includes dialysis services.

You must use network pharmacies to access Humana benefits, except under limited, non-routine circumstances when you can't reasonably use network pharmacies.

4. **If you are covered by Human and then move outside the Humana service area, you cannot continue to have Humana. You must then change your health plan to the Indemnity Health Plan.**

5. **If you have any questions or would like more information regarding Humana please contact the Trust Fund Office.**

6. The following pertains to the Summary of Benefits Chart below:

- You can go to any doctor or hospital, as long as the provider accepts Medicare and agrees to Humana's payment terms and conditions
- To find a Humana provider you can:
    - o Call 1-800-733-9064 and press 2 for Medicare Enrollment Specialist
    - o Go to Humana.com/PhysicianFinder
        - If already a member, simply click the "**Member ID**" tab and enter your Member ID, then click "**Go**" to begin your search;
        - Otherwise, under *Coverage Type* click "**Medicare or Medicare-Medicaid**," enter your zip code, and then select "**Medicare PPO**" under *Network*. You are now ready to begin your provider search. Select "**All**" for a general search or you can be more specific by choosing another available option. You can also see a list of participating hospitals by typing in the word hospital.
- No referral needed to see any healthcare provider, including specialists
- Coverage for office visits, including routine physical exams (preventive services covered at no cost to you)
- Emergency coverage anywhere in the world
- The benefit chart is a summary only, and it is subject to change. It does not fully describe your benefit coverage. For details on your benefit coverage, please refer to Humana's. *Evidence of Coverage*. The *Evidence of Coverage* is the binding document between Humana and its members.
- For details on the benefit and claims review and adjudication procedures, please refer to Humana's *Evidence of Coverage*.

Sheet Metal Workers' National Health Fund
2016 Medicare Advantage Prescription Drug Plan Option 1

Benefits	Humana Medicare Advantage Prescription Drug Plan Option 1 (MAPD Option 1)
Annual Deductible	$147
Out of Pocket Maximum	
Inpatient Hospital Coinsurance	Covered at 100%
Skilled Nursing Copayment	Covered at 100% up to 100 days
PCP (Office Visit) Copayment	Covered at 100% after annual deductible
Specialist (Office Visit) Copayment	Covered at 100% after annual deductible
Outpatient Surgical Copayment	Covered at 100% after annual deductible
Ambulance Copayment	Covered at 100% after annual deductible
Emergency Room Copayment	Covered at 100% after annual deductible
Urgent Care Visit Copayment	Covered at 100% after annual deductible
Hearing Aid	Hearing exam covered at 100% up to a $50 maximum once every 24 months. $3,000 allowance for hearing aids every 36 months

Prescription Drug		
	RETAIL **30 Day Supply**	**HUMANA MAIL-ORDER** **90 Day Supply**
Deductible	$0	$0
Initial Coverage	$5/$20/$50/$80	$0/$40/$100
Coverage Gap	$5/$20/$50/$80	$0/$40/$100
Catastrophic	Greater of $2.65 for generic/multiple source drugs ($7.40 for all others) or 5% coinsurance ($80 maximum out- of-pocket per prescription)	Greater of $2.65 for generic/multiple source drugs ($7.40 for all others) or 5% coinsurance ($100 maximum out-of-pocket per prescription)
Notes	◎ 90 day supply available at 3 times the copay amount ◎ Specialty drugs only covered as a 30 day supply	◎ Specialty drugs only covered as a 30 day supply

KAISER HMO HEALTH PLAN OPTION

If you and your eligible spouse are in the Kaiser Health Plan and are eligible for Medicare, you must complete and submit an application in order to be covered under the Kaiser Permanente Senior Advantage Program (KPSA); otherwise, you will automatically transfer to the Indemnity Medical Plan.

Important KPSA information you should be aware of:

1. You MUST enroll in Medicare Part A and Part B as soon as you are eligible under Medicare.
2. You MUST continue to pay Social Security for your Medicare Part B coverage.
3. You MUST transfer the administration of your Medicare benefits to KPSA.
4. Participants, spouses, and dependents enrolling in KPSA MUST receive all of their medical care from Kaiser providers, except authorized referrals, emergency care, and urgent out-of-the-area medical care. KPSA participants will not be reimbursed by Medicare or Kaiser for non-Kaiser medical care.
5. **If you are covered by KPSA and then move outside the Kaiser service area, you cannot continue to have KPSA. You must then change your health plan to the Indemnity Health Plan.**
6. If you are a Kaiser member and reside outside of the service area at the time you become eligible for Medicare, you are not eligible to be covered under KPSA. You must live in the Kaiser Service Area.

If you have any questions or would like more information regarding KPSA, please contact the Trust Fund Office, Kaiser at 1-800-464-4000 or visit Kaiser's website at www.kp.org.

The following pertains to the Summary of Benefits Chart on page 32:

- The benefit chart is a summary only, and it is subject to change. It does not fully describe your benefit coverage. For details on your benefit coverage, please refer to Kaiser Foundation Health Plan, Inc., *Evidence of Coverage*. The *Evidence of Coverage* is the binding document between Kaiser Health Plan and its members.
- A Kaiser Health Plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat your medical condition. The services and supplies must be provided, prescribed, authorized, or directed by a Kaiser Health Plan physician. You must receive the services and supplies at a Kaiser Health Plan facility or skilled nursing facility inside Kaiser's Service Area, except where specifically noted to the contrary in the *Evidence of Coverage*.
- For details on the benefit and claims review and adjudication procedures, please refer to Kaiser Health Plan's *Evidence of Coverage*.

Coordination of Benefits with Other Plan Benefits (Medical, Dental, Rx, & Vision)

This Plan has been designed to help you meet the cost of disease or injury. Since it is not intended that you receive greater benefits than the actual medical or dental expenses incurred, the amount of benefits payable under this Plan are subject to coordination. If you or your dependents are entitled to benefits under any other plan which will pay part or all of the expenses incurred for treatment of sickness or injury, the benefits payable under this Plan and any other plans will be coordinated so that the aggregate amount paid will not exceed 100% of the expense incurred. In no event will the amount of benefits paid under this Plan exceed the amount which would have been paid if there were no other plan involved.

Benefits under this Plan will be coordinated with any group plan providing benefits or services for hospital or medical treatment that is:

1. Group insurance coverage;
2. Blanket insurance coverage which does not contain a non-duplication of benefits or excess policy provision;
3. Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or any other arrangement of benefits provided on a group basis;
4. Any group coverage under governmental programs such as Medicare, and any group coverage required or provided by statute; and
5. No-fault auto insurance.

WHICH PLAN PAYS FIRST

If you receive benefits as an active employee under one plan and as a retiree or a COBRA participant under another, and both plans have a coordination of benefits provision, the plan covering you as an active (not laid-off or retired) employee pays first. The plan covering you as a laid-off, retired or COBRA participant pays second. If you cover a dependent under either scenario, the active coverage is primary for the dependent. If you are insured as an employee under two plans, the plan which has insured you longer is primary. If one plan does not have a coordination of benefits provision, that plan is always primary. If an eligible dependent child is covered under two plans, the plan of the parent whose birthday (month and day) is earlier in the year will pay its benefits first. If the parents of an eligible dependent child are divorced, the plan of the parent with custody of the child pays its benefits first. If the parent with custody remarries, the order of payment is as follows:

1. Natural parent with whom the child resides;
2. Stepparent with whom the child resides;
3. Natural parent not having custody of the child.

This order of payment can change if a court order specifically and unambiguously requires one of the parents to be financially responsible for the child's medical expense.

COORDINATION WITH PREPAID PLANS

The Sheet Metal Workers Health Care Plan will be considered primary for all eligible Local 104 members, regardless of whether the member has other coverage under a prepaid program under another group plan. If the member's spouse has other coverage under a prepaid plan, that prepaid plan will be considered primary for the spouse, and the Sheet Metal Workers Local 104 Health Care Plan is secondary. If an eligible dependent child is covered under two plans (the Local 104 Plan and a prepaid plan, for example), the plan of the parent whose birthday (month and day) is earlier in the year will pay the dependent's benefits first. For purposes of this Plan, the term "prepaid program" shall include health maintenance organizations (HMOs), individual practice associations, and such other programs that the Board in its sole discretion deems to be essentially similar to such prepaid arrangements.

DUAL COVERAGE UNDER THIS PLAN

1. A participant who is covered as an employee as well as a dependent under this Plan will have any claims paid first as an employee and any balance as a dependent.
2. When both parents are Plan participants, each dependent child will be considered a dependent of both for payment of any claim up to 100% of covered charges.

MEDICARE AND YOUR BENEFITS

If you are an active employee age 65 or older, the Sheet Metal Workers Local 104 Health Care Plan will pay benefits first and Medicare will pay benefits second. The Plan will also pay benefits first for certain disabled employees entitled to Medicare. The same rule applies to your covered dependents.

If you are a retired employee over the age of 65 or a disabled retiree entitled to Medicare, Medicare will pay benefits first and the Plan will pay benefits second. The same rule applies to your covered dependents.

This Plan will be secondary to Medicare except under the following circumstances:

1. The services are rendered to an active employee.
2. The services are rendered to an active employee's dependent(s).
3. The first 30 months of treatment for end-stage renal disease received by any covered person.

The Plan coordinates benefits with Medicare as if you are covered under both Medicare Part A (hospital benefits) and Part B (supplemental medical benefits). This means you must enroll in Medicare, for both Part A and Part B, as soon as you are eligible for Medicare. If you do not enroll in Medicare (Part A and Part B), the Plan will not make up for the portion of expenses that Medicare would have paid. However, the Appeals Committee may have discretion to grant appeals in certain circumstances.

> It is your responsibility to notify the Trust Fund Office once you have become eligible for Medicare.

The eligible expenses that are not paid because of copayments, deductibles, or other coverage restrictions by Medicare will be considered for payment by the Plan. If a medical procedure is not covered by Medicare but it is covered by the Plan, then the Plan will cover that service for Medicare participants in the same manner as for active participants.

You must submit your claims to Medicare before sending your claim to the Sheet Metal Workers Local 104 Health Care Plan.

THIRD PARTY LIABILITY

This Plan does not cover any illness, injury, disease or other condition for which a third party may be liable or legally responsible unless the covered person agrees to reimburse the Plan from any funds recovered from the third party or insurer. The participant and/or eligible dependents must complete and sign an agreement to reimburse in such a form or forms as the Trust Fund may require before any benefits are paid.

A participant or eligible dependent who recovers from a third party or insurer for an illness or injury must reimburse the Plan from the recovered funds for any benefits paid for the illness or injury. The participant or eligible dependent must reimburse the Plan from the recovered funds even if he or she is not otherwise made whole and regardless of whether the recovered funds are designated as payment for medical expenses.

The Plan has a right to first reimbursement from and a priority over any recovery from a third party or insurer for any illness or injury for which benefits were paid by the Plan, even if the participant and/or eligible dependent are not otherwise made whole and without regard to how the recovery is categorized. An automatic lien will arise in favor of the Plan on all funds so recovered from a third party or insurer. This lien shall remain in effect until the Plan is reimbursed. The participant and/or eligible dependent are prohibited from commingling the recovered funds with other assets or alienating or spending the recovered funds until the Plan has been reimbursed for the benefits paid on his or her behalf. The Plan shall be entitled to enforce this requirement by way of an equitable restitution lien, constructive trust, or any other equitable remedy. This Plan will be entitled to recover from the participant or eligible dependent any attorney's fees it incurs in enforcing its recovery rights under this section.

Failure to comply with the requirements of this section by the participant or eligible dependent (or their estate or guardian) may result in forfeiture of benefits under this Plan.

WORKERS' COMPENSATION

The Plan does not pay any claims arising from or related to any occupation or employment for wages or profit, whether or not the individual is covered by workers' compensation insurance. The Plan will cover claims which:

1. Workers' Compensation denies because they are non-industrial; *and*
2. Are covered under the terms of the Plan.

If any person covered under programs funded by the Plan receives workers' compensation, the Plan shall be entitled to recover the amount of any benefits paid by the Plan for services related to that illness or injury, up to the extent of such recovery by the participant or eligible dependent. Upon settlement of the claim filed with workers' compensation, the participant shall pay or cause to be paid to the Plan all amounts to which it is entitled, in accordance with

this paragraph. The participant must complete any forms required by the Plan to preserve his or her rights under this section.

The Plan will pay medical benefits for follow-up examinations on asbestosis-related cases until you or your covered dependent first suffers from an asbestosis-related "disability." A disability is defined using the same standards that are used to determine when the statute of limitations begins to run in cases of occupational disease cases under California's Workers' Compensation laws. Before the Plan will pay benefits for asbestosis-related follow-up examinations, you or your covered dependent must sign forms allowing the Plan to recover payments made to you or your dependent by Workers' Compensation. However, whether or not the forms are signed, if you or your dependent develops an asbestosis-related disability and a Workers' Compensation claim is awarded, you or your dependent must reimburse the Plan for any benefits paid for follow-up examinations. Subsequent follow-up examinations will be treated as any other claim relating to a work-related injury or illness.

Health Reimbursement Account

The Health Reimbursement Account helps you to pay Plan health care costs that you are responsible for, such as co-payments, charges that exceed what the Plan will pay, and self-pay benefits. If you are eligible, once a year, an amount determined by the Trustees will be credited to your Health Reimbursement Account. Any amounts that you do not use during the calendar year will be rolled over to the next year.

ELIGIBILITY FOR CONTRIBUTIONS

You will be eligible for a contribution to your Health Reimbursement Account if you meet any of the following rules:

Actives (including Owner/Members): You work 870 hours in a calendar year under a collective bargaining agreement of Sheet Metal Workers Local 104 in a classification for which contributions are required to be made to the Plan.

Retirees: You are actively participating in the Retiree Plan (see page 77 for Retiree Plan eligibility). If you are eligible for retiree coverage, but are not participating (you deferred your coverage until a later date), you are not eligible for the Health Reimbursement Account until such time as you actually participate in the Retiree Plan.

Disabled Participants: You have received at least (6) months of coverage in a calendar year because of your disability (see page 17 for disability coverage eligibility).

Non-Bargaining Unit Employees: You are participating in the Health Care Plan for at least (6) months in a calendar year and your employer makes the appropriate contributions to the Plan. Once you leave employment of a contributing employer, your Health Reimbursement Account is forfeited back to the Plan.

Residential Utility Worker and Maintenance Service Technician**:** Your employer is required to, and the Trust Fund receives, contributions on your behalf pursuant to the terms of the collective bargaining agreement of Sheet Metal Workers Local 104.

REIMBURSEMENT OF QUALIFIED EXPENSES

In order to qualify for reimbursement, an expense must satisfy all of the following requirements:

1. The expense must have been for medical care as defined in Internal Revenue Code § 213(d). The Trust Fund Office has a list of approved and non-approved medical expenses that is available upon request. An expense for premiums for medical coverage shall be reimbursable only if:

    - the expense is for a self-payment or COBRA payment to continue coverage for the employee or retiree and his eligible dependents under this Plan;

    - the expense is of the kind authorized under this Section;

- EXCEPTION FOR RESIDENTIAL UTILITY WORKER AND MAINTENANCE SERVICE TECHNICIAN: premium expenses are reimbursable so long as permitted by law.

2. The expense must have been incurred while you were covered by the Plan, while you are a participant of another group health plan sponsored by a sheet metal workers local union, or while employed full-time by a governmental entity under a collective bargaining agreement between the entity and Sheet Metal Workers Local 104, regardless of when the claim was made.

3. The expense must have been incurred by you or your eligible dependent(s).

4. The expense must have incurred on or after January 1, 2009.

5. You or your eligible dependent(s) must provide proof, satisfactory to the Board of Trustees, that the claim satisfies the requirements of this section.

6. Expenses incurred on or after July 1, 2011 for medicines or drugs will be reimbursed only if the medicine or drug (1) requires a prescription or (2) is available without a prescription (an over the counter medicine or drug) and the individual obtains a prescription or (3) is insulin.

7. Retirees who are eligible for coverage under the Plan, but opt out for other group health care coverage provided such group health coverage does not consist solely of excepted benefits, may be reimbursed for co-payments, co-insurance, deductibles, and premiums related to the other group health care coverage, so long as the Retiree does not work in non-covered sheet metal service.

PROCEDURES FOR PAYMENT OF REIMBURSEMENT FROM HEALTH REIMBURSEMENT ACCOUNT BENEFITS

1. Benefits will be paid only to you or eligible dependents. Benefits will be paid only after an eligible person has incurred a Qualified Expense, and submitted a claim with supporting documents. Assignment of Health Reimbursement Account benefits is not allowed.

2. Claims may be submitted at any time. Payment of claims will be subject to the regular claims payment procedure of the Plan. If you or your eligible dependent's claim is denied, you may appeal that denial to the Board of Trustees, under the general appeal procedures provided elsewhere in the Plan.

DISPOSITION UPON YOUR DEATH OR TERMINATION OF HRA PROGRAM

If you die with any credits remaining in your Health Reimbursement Account and other coverage is exhausted, your surviving eligible dependents may elect COBRA continuation coverage. Your Health Reimbursement Account may then be used to pay COBRA continuation coverage or other qualified expenses. If your Health Reimbursement Account falls below the monthly charge-off prior to the ending of COBRA continuation coverage, the surviving dependent(s) will have the right to self-pay the remainder of COBRA eligibility. If you die and there are no dependents eligible for coverage, your account shall be forfeited to the general assets of the Plan.

The Health Reimbursement Account is funded only by employer contributions, -and is not a vested benefit. This program may be terminated by the Board of Trustees at any time, in which event the HRA accounts shall revert to the general assets of the Plan.

WAIVING YOUR HRA

You are permitted to permanently opt out of and waive future reimbursement from the Health Reimbursement Account. If you elect to waive future reimbursement, your account shall be forfeited to the general assets of the Plan. Your Health Reimbursement Account will not be reinstated at a later time for any reason.

Claims and Appeals Procedures

FILING OF CLAIM FORMS

All claims for benefits must be filed with the Trust Fund Office in writing. A claim will be considered filed upon receipt by the Trust Fund Office provided it is substantially complete, with all necessary documentation required by the Plan. If the information is incomplete, or if required documentation has not been furnished, you will be notified of what is necessary to complete the claim. ***It is your responsibility to file claims in a timely manner.*** The Trust Fund Office requires, at a minimum, the following information: employee's name, Social Security Number, address, home telephone number, employer name, patient's name, patient's relationship to insured, patient's sex, patient's date of birth, spouse's name, spouse's Social Security Number, spouse's date of birth, whether spouse has group insurance, whether patient's work caused this condition, the first day the patient was unable to work, the date the patient has returned to work (if applicable), and documentation from the doctor to substantiate that services were rendered, including a diagnosis and diagnosis code. Also, all itemized bills must be attached, including any certification(s) from Blue Shield.

Whenever you believe you or one of your eligible dependents is entitled to hospital, medical, surgical or dental benefits, follow these steps for prompt claim settlement:

1. Obtain a claim form from the Trust Fund Office or the local union office. Forms supplied by hospitals and physicians are usually acceptable substitutes for claim processing.
2. Fill out your portion of the form completely.
3. Have your doctor or dentist complete his/her portion of the form.
4. Attach all itemized bills relating to the claim to the completed claim form. Only <u>itemized</u> bills, showing the date of service and the charge and description for each service, will be accepted. Incomplete forms and un-itemized bills will delay the processing. Note: hospital bills will usually be submitted directly to the Trust Fund Office by the hospital.
5. Submit the claim to:

Sheet Metal Workers Local 104 Health Care Plan
P.O. Box 1618
San Ramon, CA 94583

6. Before proceeding with treatment, be sure you know what the charges will be. Remember, you will be responsible for paying any difference between the total bill and the amount paid by the Plan.
7. The Plan may require submission of x-rays and other supporting documentation. When the necessity of treatment is not established to the satisfaction of the Plan, benefits may be reduced or denied.

The Plan also may require an examination of a claimant, at its own expense, before approving payment.

Claims should be submitted to the Trust Fund Office at the above address within 90 days after the date the treatment began. Claims submitted more than 12 months after treatment began will not be paid. If this Plan is secondary or tertiary, claims must be submitted no later than 2 years from the date of service and no later than 12 months from the processing date of the primary carrier.

If the claim information is incomplete, or if required documentation has not been furnished, you will be notified of what is necessary to complete the claim and will have 45 days to provide the requested information, or until the expiration of the timely filing period (if the Plan is primary: 12 months from the date treatment began; if the Plan is secondary or tertiary: 2 years from the date of service and no later than 12 months from the processing date of the primary carrier), whichever is later.

Claims for persons eligible to receive Medicare Part A and Part B must be accompanied by a copy of the Medicare Explanation of Benefits.

NOTE: You are responsible for verifying that the claim is submitted to the Trust Fund Office. Do not leave the claim form with your doctor and assume that it will be presented on your behalf. The eligible employee must sign the form.

ASSIGNMENT OF BENEFITS

The rights, coverage, and eligibility of a participant, employee, beneficiary, or dependent under this Plan, or under any applicable law, may not be assigned. A direction to pay a provider is not an assignment of any right under this Plan or any legal or equitable right to institute any court proceeding.

DEATH BENEFIT CLAIMS

Application for death benefits must be received, by the Trust Fund Office, within 12 months of the loss for any benefit to be payable. A certified copy of the death certificate must be attached with a completed claim form.

APPEALS PROCEDURES

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

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

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

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

Emergency Care Claims

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

Pre-Service Claims

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

Post-Service Claims

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

Concurrent Care Decision

If you are receiving an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of such treatment will be deemed an adverse benefit determination. Notice of such determination will be sent at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

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

Benefit Determination on Review

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

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

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

Emergency Care Claims

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

Pre-Service Claims

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

Post-Service Claims

Upon receipt of a petition for review, the Trustees or a committee appointed by the Trustees and authorized to act on such petitions, will proceed to review the administrative file, including

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

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

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

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

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

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

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

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

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

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

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

The Trustees have full discretionary authority to interpret all plan provision and to make all factual determinations concerning any claim or right asserted under or against the Plan or Trust

Fund. The Trustees and/or the Appeals Committee have absolute discretion to grant an appeal if, based on the specific facts and circumstances, it is in the best financial interest of the Plan.

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

LIMITATION OF LIABILITY

Benefits are not guaranteed under this Plan. The benefits provided by this Plan, and the premiums required by Kaiser Permanente Health Plan, are payable out of the Trust Fund and only to the extent the funds are available in the Trust Fund for that purpose.

PROVISIONS UNDER THE AFFORDABLE CARE ACT

Effective October 1, 2011, in addition to the claims and appeal provisions above, the following provisions under the Patient Protection and Affordable Care Act (the "Act") are applicable to the Plan:

1. An adverse benefit determination eligible for internal claims and appeals includes a rescission of coverage. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect.
2. The Plan is required to provide you (free of charge) with new or additional evidence considered, relied upon, or generated by (or at the direction of) the Plan in connection with your claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for you to respond to such new evidence or rationale.
3. The Plan must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to an individual (such as claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.
4. Notices must be provided in a culturally and linguistically appropriate manner and must include the additional requirements provided under the Act, including: (i) information sufficient to identify the claim involved; (ii) a denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim; (iii) a description of available internal appeals and external review processes and how to initiate an appeal; and (iv) the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act.
5. If the Plan fails to strictly adhere to all the requirements of the applicable regulations under the Act as they pertain to your claim or appeal, you are deemed to have exhausted the Plan's internal claims and appeals process, regardless of whether the Plan asserts that it has substantially complied, and you may initiate any available external review process or remedies available under ERISA.
6. Certain adverse benefit determinations including those involving medical judgment or a rescission of coverage are entitled to an external review. The Plan is required to pay the cost of an independent review organization (IRO) to conduct the external review. You

are entitled to request an external review after receipt of an adverse benefit determination, in accordance with applicable regulations under the Act as described below:

Standard External Review

(a) Request for External Review: You may file a request for an external review with the Plan within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of a notice, then your request must be filed by the first day of the fifth month following the receipt of notice. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next date that is not a Saturday, Sunday, or Federal holiday.

(b) Preliminary Review: Within five business days following the date of receipt of the external review request, the Administration Office will complete a preliminary review of the request to determine whether:

(i) You are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;

(ii) The adverse benefit determination or the final adverse benefit determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan;

(iii) You have exhausted the Plan's internal appeal process; and

(iv) You have provided all the information and forms required to process an external review.

Within one business day of completion of the preliminary review, the Plan will issue a notification to you or your authorized representative informing you whether your claim is eligible for external review. If your request is complete, but not eligible for external review, the notification will include the reasons for ineligibility and contact and support information from the Employee Benefits Security Administration. If the request is incomplete, the notification will describe the information or materials needed to make the request complete, and the Plan will allow you to perfect your request for external review within the four-month filing period or 48 hours of your receiving the notification whichever is later.

(c) Referral to Independent Review Organization: The Plan will assign an independent review organization (IRO) that is accredited to conduct an independent external review. The Plan uses three independent review organizations and rotates claims among them to ensure an independent review. The IRO will observe the following procedures:

(i) The IRO will use legal experts where appropriate to make coverage determinations under the Plan.

(ii) The assigned IRO will timely notify you of your claim's acceptance for external review. You will be given ten business days to submit additional information to the IRO and the IRO will consider that information in making a determination on your appeal. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

(iii) Within five business days after the date of assignment of the IRO, the Plan will provide to the assigned IRO the documents and any information

considered in making the adverse benefit determination or final internal adverse benefit determination. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or adverse final internal adverse benefit determination. Within one business day after making the decision, the IRO will notify you and the Plan.

(iv) Upon receipt of any information submitted by you, the assigned IRO must within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. The external review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day of making such a decision, the Plan will notify you and the IRO and the IRO will then terminate the external review.

(v) 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 will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals procedure. 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: (a) your medical records; (b) the attending health care professional's recommendation; (c) reports from appropriate health care professionals and other documents submitted by the Plan, you, or your treating provider; (d) the terms of the 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; (e) 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; (f) 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 (g) the opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

(vi) The assigned IRO must provide written notice 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.

(vii) The assigned IRO's decision notice will contain: (a) 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 previous denial); (b) the date the IRO received the assignment to conduct the external review and the date of the decision; (c) references to evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching the decision; (d) 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; (e) 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 you; (f) a statement that judicial review may be available to you;

(g) current contact information for the health insurance consumer assistance or ombudsman.

(viii) After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by you, the Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

(d) Reversal of the Board of Trustees' Decision: Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

(a) Request for Expedited External Review: You will be permitted to make a request for expedited external review if you receive (1) an adverse benefit determination if the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your ability to gain maximum function and you have filed a request for an expedited internal appeal; or (2) a final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to gain 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 you received Emergency Services, but have not been discharged from a facility.

(b) Preliminary Review: Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request is eligible for external review and will not immediately send you a notice regarding whether the claim is eligible for external review.

(c) Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO for review. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or by facsimile or by any other expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decision or conclusion reached during the Plan's internal claims and appeal process.

(d) Notice of final external review decision. The assigned IRO will provide notice of the final external review decision, as expeditiously as the claimant's medical condition or circumstance 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 or providing that notice, the assigned IRO must provide written confirmation of the decision to you and the Plan.

WAIVER OF CLASS, COLLECTIVE AND REPRESENTATIVE ACTION

By participating in the Plan, Participants waive, to the fullest extent permitted by law, whether or not in court, any right to commerce, be a party in any way, or be an actual or putative class member of any class, collective, or representative action arising out of or relating to any dispute, claim or controversy relating to the Plan, and Participants agree that any dispute, claim or controversy may only be initiated or maintained and decided on an individual basis.

Definition of Terms

CONTRACT PROVIDER

"Contract Hospital" or "Contract Provider" means a hospital, facility, physician or other health care provider that has a contract in effect with the Preferred Provider Organization (PPO) under contract with the Plan.

COPAYMENT

"Copay" and "Copayment" means the amount the eligible participant is required to pay for a service or drug before Plan benefits are payable.

COSMETIC SURGERY

Surgery that is not intended to correct normal functions of the body but is performed to improve the appearance of the patient or to preserve or restore a pleasing appearance.

COVERED EMPLOYMENT

Covered Employment is any of the following:

1. Employment under a written Collective Bargaining Agreement between Sheet Metal Workers Local 104 and an industry employer requiring contributions to this Plan on the employee's behalf.

2. Employment with a participating local union or apprenticeship office, or a related organization, for which the employer has agreed in writing, with the approval of the Trustees, to pay the required contribution.

COVERED INDIVIDUAL

An individual covered under this Plan.

CUSTODIAL CARE

Custodial care means treatment, services or confinement which could be rendered safely and reasonably by a person not medically skilled, and which are designed mainly to help the patient with activities of daily life. Custodial care includes personal care, homemaking services, moving the patient, acting as companion or sitter, or supervising medication which can usually be self-administered. **Custodial care is not covered under the Plan.**

DEDUCTIBLE

There is a deductible for all employees in the Indemnity Plan as follows: $300 per person per calendar year, with a family maximum of $600 per calendar year. Covered expenses incurred in the last 2 months of a calendar year may be applied to the deductible for that year and toward the deductible for the following year as well.

DENTAL TERMS

BENEFITS means those dental services which are provided under the Dental Plan and described in this booklet.

DENTIST means a duly licensed dentist legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed.

EMERGENCY SERVICES means only those dental services immediately required for alleviation of severe pain, swelling or bleeding, or immediately required to avoid placing the patient's health in serious jeopardy.

USUAL, CUSTOMARY AND REASONABLE (UCR) means fees for dental services which are considered reasonable and customary when they are within the range of usual fees charged and received by dentists of similar training, within the geographic area, for the same services. These charges are automatically updated twice each year by a nationally recognized index—an independent organization that surveys the charges for various procedures.

EMERGENCY CARE

An emergency is defined by the Plan as a sudden occurrence of a medical condition which, if not treated immediately, may result in permanent health problems, serious medical complications, serious impairment of bodily functions or serious or permanent dysfunction of a bodily organ or part. As defined by the Plan, in an emergency the symptoms are severe, occur suddenly and unexpectedly and require immediate attention.

Examples of emergency conditions are:

- Severe chest pain
- Uncontrolled bleeding
- Loss of consciousness
- Severe shortness of breath
- Poisoning
- Sudden onset of paralysis and/or slurred speech
- Severe burns
- Broken bones

Care will not be considered to be an emergency unless it is sought and given immediately (usually within 24 hours) after the sudden onset of symptoms.

EXPERIMENTAL OR INVESTIGATIVE SERVICES

Investigational services are defined as those drugs, equipment, procedures or services for which laboratory and animal studies have been completed and for which human studies are in progress but: (a) testing is not complete; and (b) the safety of such services in humans has not yet been established; and (c) the service is not in wide usage as an accepted form of treatment. Investigational services are not covered by the Plan except when all of the following conditions are met:

1. Conventional therapy will not adequately treat the patient's condition;
2. Conventional therapy will not prevent progressive disability or premature death;
3. The provider of the service has a record of safety and success with the service which is equivalent or superior to that of other providers of the proposed service;
4. The investigational service is the lowest cost item or service that meets the patient's medical needs and is less costly than all other conventional alternatives;
5. The service is not being performed as part of a research study;
6. There is a reasonable expectation that the investigational service will significantly prolong the intended patient's life or will maintain or restore physical or social function suited to the activities of daily living.

HOME HEALTH CARE

An agency qualified as such under Medicare.

HOSPICE CARE

Palliative care for terminally ill patients. 'Palliative care' is care that is rendered to relieve the symptoms or effects of a disease without curing the disease.

HOSPITAL

Hospital means a properly licensed institution which is primarily engaged in providing, for compensation from its patients, medical, diagnostic and surgical facilities for the care, treatment of disabled, injured and sick persons on an inpatient basis, which provides such facilities under the supervision of a staff of physicians, and with 24-hour-a-day nursing service by registered professional nurses. In no event, however, shall such term include any institution or part thereof which is used principally as a rest facility, nursing facility, convalescent facility, residential treatment center or facility for the aged or the care and treatment of alcohol and substance abuse, except as mandated by state law, or any institution that makes a charge that the patient would not be legally required to pay in the absence of this Plan. The following describes two levels of inpatient care:

1. Acute Care. The acute level of care is for a patient with a medical condition that requires:

- A continued availability of medical supervision and/or other medical consulting staff.
- The continuing availability of licensed nursing personnel.
- The immediate availability of other diagnostic or therapeutic services and equipment present only in acute care facilities.

2. Sub-acute Level of Care. The sub-acute level of care is an alternative to acute care for inpatient medically stable patients who require intense, highly technical services. The programs (or units) provide comprehensive medical, nursing and rehabilitative services (and can include all other modalities of care found at the acute level of care) using an integrated interdisciplinary approach.

HOSPITAL MISCELLANEOUS CHARGES

Those covered charges made by the hospital for other than room and board. Miscellaneous charges include, but are not limited to, diagnostic radiology and pathology, including the professional services in connection with radiology and pathology, the operating room, radiation therapy and medically necessary drugs and medical or surgical supplies and the use of hospital equipment while the patient is confined to the hospital.

MEDICALLY NECESSARY SERVICES

Services or supplies which are determined by the Plan to be appropriate and necessary for the condition being treated, in accordance with standards of good medical or dental practice, and not for the convenience of the patient or provider of services. The treatment must be one that cannot be excluded without adversely affecting the patient's condition. The fact that services or supplies are prescribed by a physician does not mean that they are medically necessary. Medical necessity also applies to the type of facility in which you receive care, and the level of care. The Plan does not consider hospitalization medically necessary if the care could be adequately provided in a less expensive facility such as a skilled nursing facility, outpatient clinic, or at home.

MEDICARE

Medical benefits provided by Title XVIII of the Federal Social Security Act.

MENTAL DISEASE OR DISORDER

The term "Mental Disease or Disorder" means any mental disease or disorder, whether the cause is organic, physical, mental or environmental, or any combination thereof, or whether the symptoms are physical, mental or a combination thereof.

Any condition meeting this definition is included in it regardless of whether it produces only emotional symptoms or only physical symptoms such as headaches, sweats, trembling, nausea, or hysterical paralysis, or a combination of both. Plan limitations or exclusions of treatment of mental disease or disorder apply to the treatment of all conditions meeting this definition.

Examples of mental diseases or disorders include (but are not limited to) those which fall within the diagnosis codes 290 through 290.9 or 293 through 301.9 or 306 through 316 as listed in the "International Classification of Diseases," 9th Revision, Clinical Modification, Volumes 1 and 2, such as: schizophrenia, manic depression and other conditions usually classified in the medical community as psychosis; depressive, phobic, manic and anxiety conditions (including panic disorders); bipolar affective disorders including mania and depression; obsessive compulsive disorders; autism; hypochondria; personality disorders (including paranoid, schizoid, dependent, antisocial and borderline); dementia and delirious states; post-traumatic stress disorder; cumulative trauma syndrome; organic brain syndrome; hyperkinetic syndromes (including attention deficit disorders); adjustment reactions; reactions to stress; anorexia nervosa and bulimia.

OUTPATIENT SURGICAL CENTERS

An outpatient surgical center is considered a hospital if the outpatient surgical center meets the following conditions:

1. The center must meet the basic definition of a hospital, other than providing overnight facilities and the 24-hour nursing services.

2. The facility must be licensed or AHC certified as an outpatient surgical center.

3. The center must have an organized medical staff of physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, and with continuous physician services and registered professional nursing services whenever a patient is in the facility, and must not provide services or other accommodations for patients to stay overnight.

OWNER/MANAGER

For purposes of Fund coverage, an owner/manager is defined as a person (or the person's spouse) who owns stock in the corporation or who is reported as a partner or sole proprietor of the company on its federal tax returns and who does not perform work covered under the Collective Bargaining Agreement. The person may or may not belong to the Union, and more than one person may qualify as manager.

The Plan does not accept contributions on behalf of owner/managers unless the employer regularly employs at least one employee covered by the Collective Bargaining Agreement. For purposes of Plan coverage, the term "regularly employs" shall mean that the employer has at least one bargaining unit employee on its payroll and contributes to the Plan on behalf of such employee(s) for a total of at least 870 straight time hours during each Plan year (July1 to June 30).

If an employer enrolls any non-collectively bargaining unit employees, it must enroll all of its full-time non-collectively bargaining unit employees as of the first of the month after they are hired as full-time employees.

To be considered eligible for coverage as a non-bargaining unit employee, the individual must provide satisfactory evidence that he or she actively works at the employer's principal place of business, which cannot be the employer's residence, and:

1. If the business is incorporated, the individual must be on the employer's payroll for at least 142 hours per month at no less than minimum wage; or
2. If the business is **not** incorporated, the remuneration for the partner on the K-1 must equal or exceed 1,704 hours per year at minimum wage.

OWNER/MEMBER

For purposes of Fund coverage, an owner/member is a person who is a member of the Union, who owns stock of the employer (or whose spouse owns such stock), or who is reported (or whose spouse is reported) as a partner or sole proprietor of the company on its federal tax returns, and who is included in the unit covered by the employer's Collective Bargaining Agreement with the Union.

Owner/members have a right to maintain an Hour Bank for purposes of extended eligibility consistent with the Hour Bank provisions for bargaining unit employees. However, an owner/member may draw on the Hour Bank only after he or she ceases operation as an owner/member, no longer maintains an active contractor's license, signs the out-of-work list with the Union, and is actually available for work. If the owner/member's company continues to operate, a presumption shall exist that the owner/member is employed by that company and is not available for work. Each owner/member who accepts coverage under this Fund agrees that if he or she ceases to be an owner/member and returns to covered employment, all payments received by the Fund for hours of such employment in excess of 115 hours per month (or 130 hours per month, as applicable) shall be applied to satisfy any outstanding obligations of the owner/member's company pursuant to its Collective Bargaining Agreement with Local 104 which are attributable to the period of owner/member status. The former owner/member shall receive no Hour Bank credit for such excess hours until all such obligations have been satisfied.

To be considered eligible for coverage as an owner/member, the individual must provide satisfactory evidence that he or she actively works at the employer's principal place of business, which cannot be the employer's residence; and:

1. If the business is incorporated, the individual must be on the employer's payroll for at least 142 hours per at no less than minimum wage; or
2. If the business is **not** incorporated, the remuneration for the partner on the K-1 must equal or exceed 1,704 hours per year at minimum wage.

PARTIAL HOSPITALIZATION/DAY TREATMENT

The partial hospitalization/day treatment level of care is an alternative to acute inpatient psychiatric care. Patients in this setting require an intensive treatment structure for 4 to 8 hours per day but are able to return to a supportive home environment at night.

PHYSICIAN OR DOCTOR

Physician or doctor means, with respect to any particular medical care and surgical services, any holder of a certificate or license authorizing such holder or licensee to perform the particular medical or surgical services. The term "physician" shall not include the eligible

employee or dependent; or the spouse, parent, child, sister or brother of the eligible employee or dependent.

PREFERRED PROVIDER ORGANIZATION (PPO)

Preferred provider means a doctor, hospital, outpatient surgical center or laboratory rendering services at reduced rates in accordance with the agreement with the Preferred Provider networks, including Blue Shield for the hospital and physician network, WellDyneRx for the pharmacy network, Beat It! for alcohol and substance abuse, and Blue Shield for utilization review and case management.

No health care provider is an agent or representative of the Plan. The Plan does not control or direct the provision of health care services and/or supplies to plan participants and beneficiaries by anyone. The Plan makes no representation or guarantee of any kind concerning the skills or competency of any health care provider. The Plan makes no representation or guarantee of any kind that any provider will furnish health care services or supplies that are malpractice-free.

The foregoing statement applies to any and all health care providers, including both preferred and non-preferred providers under the terms of the Plan. The statement also applies to all entities (and their agents, employees and representatives) which contract with the Plan to provide utilization review or to offer HMO coverage, preferred provider networks or other health-related services or supplies to participants and beneficiaries, including but not limited to Blue Shield, Beat It!, WellDyneRx, and Kaiser Permanente.

Nothing in this Plan affects the ability of a provider to disclose alternative treatment options to a participant or beneficiary.

PROVIDER

1. A licensed Medical Doctor (M.D.)
2. A licensed Doctor of Osteopathy (D.O.)
3. A Chiropractic Doctor (DC) (under certain limited conditions).
4. A Doctor of Medical Dentistry (D.M.D.)
5. A Doctor of Dental Surgery (D.D.S.)
6. A Doctor of Podiatry (D.P.M.)
7. A Physical Therapist or Occupational Therapist
8. A Psychologist (Ph.D.)
9. A Master of Social Work (L.C.S.W., M.S.W., and M.F.C.C.)
10. An Ophthalmologist (M.D.) or an Optometrist
11. A Certified Nurse Anesthetist
12. A Registered Nurse as First Assistant (R.N.F.A.), under the supervision of a Medical Doctor
13. A Physician Assistant (P.A.)

14. A licensed Midwife
15. A licensed Denturist

A provider does not include a person who lives in your home or who is related to you by blood or marriage.

ROOM AND BOARD CHARGES

Charges made by a hospital or skilled nursing facility for the room, meals, and routine nursing services for covered individuals confined as bed patients.

SKILLED NURSING CARE

This level of care provides inpatient care for a person with a medical condition requiring services by or under the direct supervision of licensed personnel under the general direction of a physician, which is needed to assure the safety of the patient or to achieve the medically desired result. In this level of care the patient's medical needs require the availability of skilled nursing services on a continuing basis but not the constant availability of the medical services of an acute hospital. The patient's condition is not yet stabilized and he/she is receiving one or more skilled or rehabilitative services.

SPEECH THERAPIST

Someone who has a master's degree in speech pathology and has completed an internship and is licensed by the state in which he or she performs his or her services, if that state requires licensing.

USUAL, CUSTOMARY AND REASONABLE (UCR) CHARGES

Charges which fall within the common range of fees billed by a majority of health care providers for a procedure in a given geographic region, or which is justified based on the complexity or the severity of treatment for a specific case as determined by the Plan.

For comprehensive health plan benefits, this Plan further defines Usual, Customary and Reasonable charges as those charges which do not exceed the 90th percentile of the Prevailing Health Care Charges as published by a nationally recognized index.

The usual, customary and reasonable limits for surgical and medical charges are automatically updated twice a year. Any fees exceeding the Plan's usual, customary and reasonable limits are not considered eligible expenses and are not covered by the Plan. When you use a contract hospital or other preferred provider, the eligible expenses are based on a special negotiated rate which is always within the reasonable and customary limit.

Supplemental Unemployment and Supplemental Health Care Benefits

SUPPLEMENTAL UNEMPLOYMENT BENEFITS

Supplemental Unemployment Benefits are provided to Participants in the sheet metal industry working under the jurisdiction of Local Union No. 104 as an addition to weekly State Unemployment, State Disability or Workers' Compensation Benefits received during periods of lay-off or disability. Residential Utility Workers and Maintenance Service Technicians are not eligible for this benefit.

ELIGIBILITY REQUIREMENTS

You will be initially eligible for Supplemental Unemployment Benefits (SUB) provided you have accumulated twenty-six (26) credits in your account based on contributions made on your behalf by a contributing Employer within a 24-month period, and you meet one of the following requirements:

a. **Involuntary Termination of Employment**
you are involuntarily separated from employment, and:

   1. are signed on an out-of-work list, which is maintained by a Sheet Metal Workers' Local Union No. 104 Dispatch Office and available for work, and **have not refused work covered under the Collective Bargaining Agreement or otherwise not been available for such work**; and
   2. are receiving State Unemployment Benefits; or

b. **Jury Duty**
you are serving on a jury or as a witness under subpoena for two (2) or more days; or

c. **Occupational Sickness or Injury**
you are unemployed due to an occupational sickness or injury and are receiving Workers' Compensation Benefits; or

d. **Non-occupational Sickness or Injury**
you are unemployed due to non-occupational sickness or injury and are receiving State Disability Benefits.

e. If you are an Apprentice attending daytime classes at an Apprentice School affiliated with Sheet Metal Workers' Local Union 104, you may be eligible for benefits for each full week of classes attended for each new week. Benefits will not be paid for training of less than one week, or for a class that you are retaking, unless authorized by the Bay Area JATC Board of Trustees.

   Benefits are payable for a maximum of five (5) weeks for each year of training. Effective January 1, 2012, benefits are payable for a maximum of six (6) weeks for each year of training.

Apprentices that are employed are not required to be on the out of work list.

To receive benefits, you must file an Apprentice Training Benefit Application (including the Instructor's or Coordinator's signature) with the Trust Fund Office, be a member of Sheet Metal Workers' Local Union No. 104, and be a Certified Apprentice in accordance with the Bay Area Training Trust rules. The Apprentice Unemployment Benefit Application will be submitted to the Trust Fund Office on a weekly basis, but no later than sixty (60) days after the completion of the course.

Credits for Apprentices will be drawn from any credits earned. However, if you have not earned sufficient credits, the Plan will advance the benefits, which will be deducted from credits that are later earned. You will not be eligible for Apprentice Training benefits when receiving Supplemental benefits through the Local 104 Health Care Plan while on disability or other period of unemployment.

If you become eligible for EDD benefits because of "shelter in place" mandates issued by any city, county or the State of California, you will be eligible for SUB benefits for up to twelve (12) weeks. In this limited circumstance, if your EDD check stubs states a first claim date of March 16, 2020 or later, you will not be required to sign the out-of-work list. A revised SUB application is available for SUB coverage under this provision.

WARNING

Should you retire pursuant to the terms of the Sheet Metal Workers of Northern California Pension Plan or any other pension benefits provided by a plan within the Sheet Metal Industry, you will be required to reimburse this Plan for any payments you have received for any period on or after the effective date of your retirement (see page 79). You are also required to pay 10% (ten percent) annual interest on the outstanding balance required in the event repayment in full is not made within ninety (90) days of notification that repayment is required.

CREDIT ACCOUNT

A credit account will be established for each Participant for whom Employer contributions have been received by the Plan. Credits are accumulated as follows:

a. For each month you work at least twenty-four (24) hours but less than forty-eight (48) hours and your Employer has made contributions on your behalf for such months, you will be credited with one (1) eligibility credit.
b. For each month you work forty-eight (48) hours or more and your Employer has made contributions on your behalf for such months, you will be credited with (2) eligibility credits.

The maximum number of credits that may be accumulated in your credit account is twenty-six (26). One (1) credit will be cancelled for each weekly SUB benefit you receive.

The balance of your account will be recalculated each month to reflect credits earned and credits cancelled during the month. If you have a positive balance in your account and meet the eligibility requirements, you are able to use credits for benefits.

If no contributions are made to the Fund on your behalf for a period of twenty-four (24) consecutive months or more, your credits will be cancelled and you must re-qualify for initial eligibility.

If you are in the US Military Reserve and you are called to active duty, by providing evidence of your status to the Fund Office, your account will be frozen for the duration of your active duty. If you return to work within 60 days from discharge, your account will be reinstated provided you meet the eligibility rules provided herein.

AMOUNT OF BENEFITS

The amount of the SUB benefit payable to a Participant who has been involuntarily terminated shall be $150.00 per week, except that each Participant collecting Workers' Compensation or State Disability shall be entitled to $160.00 per week. Participants serving on a jury or as a witness under subpoena for two (2) or more days shall be entitled to a weekly benefit of $150 per week, to the extent eligible.

An additional amount, intended to partially offset the current monthly union dues, is paid to a Participant collecting Workers' Compensation or State Disability, is disabled according to Fund records for at least three (3) months, and is certified as disabled by Local Union No. 104. This additional amount is determined by the Board of Trustees, and may change from time to time.

DURATION OF BENEFITS

The benefit is payable for up to twenty-six (26) weeks in any benefit year based on the amount of credits available in your credit bank. However, if you are unemployed due to a disability, you may receive an additional twenty-six (26) weekly payments provided you continue to satisfy the eligibility requirements.

1. A participant may receive a single 26-week disability extension so long as he or she meets all other applicable SUB requirements. The number of disability extension credits shall be limited to the number of SUB credits the participant earned through employment.

2. A participant may receive another disability extension if he or she returns to work and earns additional SUB credits. The amount of disability extension credits that may be granted shall not be greater than the number of SUB credits earned through employment.

3. Should a participant who is on a disability extension not use all of their credits, the extension credits will expire. If the participant returns to work, earns SUB credits and later becomes disabled, any extension granted will be limited to the number of SUB credits he or she earned when he or she returned to employment.

4. Should a participant begin receiving SUB payments based on unemployment claims and later convert to disability, the participant will be eligible for a SUB extension up to the credits available at the time payment of SUB began (i.e., participant has 15 weeks of SUB, uses 5 based on unemployment claims, and the remainder are disability claims, the participant is eligible for a 15-week disability extension). The last payment made to the participant based on SUB credits earned must be for a disability before the extension will be considered.

APPLICATION FOR BENEFITS

If you wish to file a claim for Supplemental Unemployment Benefits, go to your nearest Local Union No. 104 Dispatch Office and complete the application form. If you are disabled, you should contact the nearest Local Union No. 104 Dispatch Office and an application form will be sent to you. Please return the application to your Local Union No. 104 Dispatch Office, as **all applications must be approved by a Union Business Representative before benefits can be paid**.

You may file for benefits by sending to the Trust Fund Office proof of claim within 90 days of the date you become unemployed, or within 120 days of the date you become disabled. Proof of claim must be in the form of a check stub or other evidence of receipt of State Unemployment, State Disability or Workers' Compensation. Your proof of claim must have your name, social security number and the dates of your unemployment or disability.

All claims for SUB benefits must be filed immediately upon becoming unemployed. Your first SUB benefit check will cover the **later** of:

a. The 90 days preceding the date of filing of your application for unemployment (120 days for disability), or
b. Your first week of unemployment during which you receive State Unemployment, State Disability or Workers' Compensation benefits.

TO RECEIVE PAYMENT ON THURSDAY, YOUR STUBS MUST BE RECEIVED BY THE FUND OFFICE NO LATER THAN 12:00 P.M. THE PRECEDING WEDNESDAY, PROVIDED IT IS NOT A HOLIDAY.

In addition, you are required to submit evidence of receipt of State Unemployment, State Disability or Workers' Compensation Temporary Disability payments to the Trust Fund Office in the form of State-benefit check stubs, **BEFORE** any SUB benefit check will be issued by the Trust Fund Office. In the event check stubs are submitted more than 90 days after the last day of any weekly period for which a SUB benefit has been or may be claimed, that weekly benefit period will be disqualified and no SUB benefit will be paid for that weekly period. The 90-day period will be extended to 120 days if you are disabled.

Non-consecutive claims filed for SUB will cause an interruption in your receipt of benefits, and is subject to investigation by the Trust Fund.

METHOD OF PAYMENT

Once you are eligible for benefits, a weekly direct deposit will be made into your Vacation account at the Local 104 Credit Union. You can access your supplemental unemployment funds through an ATM or simply have the Credit Union issue you a check on the day the funds are deposited to your account. Contact the Local 104 Credit Union at (800) 464-5987 to confirm benefit payments are received.

INELIGIBILITY FOR BENEFITS

You are not eligible for benefits if you meet any of the following:

a. Entitlement to a Pension. You are not eligible for benefits if you receive pension benefits under the Sheet Metal Workers of Northern California Pension Plan or any other pension benefits provided by a plan within the Sheet Metal Industry for any period in which you received benefits under this Plan. This section does not apply if you are receiving temporary disability benefits under the Local 104 Supplemental Pension Plan.

b. Voluntary Termination of Your Employment. You are not eligible for benefits if you voluntarily terminate your covered employment.

c. Refuse Work or Unavailable for Work. You are not eligible for benefits if you refuse work covered under the Collective Bargaining Agreement or you are otherwise not available for work.

d. Entitlement to Social Security Benefits. You are not eligible for benefits if you receive Social Security benefits.

e. Denial of State Benefit Because of Labor Dispute. You are not eligible for benefits if you are denied a State-benefit based on an adjudication that you are unemployed because of a labor dispute.

f. Failure to Attend Class/Comply with JAC Rules. You are not eligible for benefits if you are a Participant of a Local 104 Apprenticeship or Training Program, and you fail to attend required regularly scheduled apprenticeship/training classes during the period of a layoff. Similarly, if you do not attend required Joint Apprenticeship Committee (JAC) classes, you are no longer eligible for benefits under the Plan.

g. Work in Non-Covered Sheet Metal Work. You are not eligible for benefits if you perform work which constitutes covered work under the Collective Bargaining Agreement for a person or entity which is not an 'Employer' (as defined below), or you engage in such work as an independent contractor, proprietor, partner or owner. Work in Non-Covered Sheet Metal Work will result in the cancellation of your entire accumulated credits.

   'Employer' shall mean any contractor member of the Sheet Metal Workers' Local Union No. 104 and the Bay Area Sheet Metal and Air Conditioning Contractors National Associations, and Independent Contractor Associations of any Signatory Individual Employer or any Individual Employer who has a Collective Bargaining Agreement with the Union providing for the payment of Employer contributions into the Trust Fund. The term Employer shall also include the Union, participating Trust Funds and Employers of apprentices whose employment is pursuant solely to an Apprenticeship Contribution Agreement.

h. Material Misrepresentation/Willful Violation. If the Trustees determine that you engaged in a material misrepresentation in connection with your application for benefits under this Plan, or you have engaged in a willful violation of Plan rules, the Trustees have the authority to cancel all or part of your accumulated credits in your credit account. A willful violation may also cause you to become ineligible for future retiree benefits under this Plan.

APPEALS PROCEDURES

If your claim for Supplemental Unemployment Benefits is denied, you may submit a written appeal to the Trustees in accordance with the procedures on page 94 of this booklet.

The following table summarizes the benefits for the Supplemental Unemployment Benefit and the Supplemental Health Care Benefit.

	Supplemental Unemployment Benefit (SUB)	**Supplemental Health Care (SHC)**
Credit Accumulations for Initial Eligibility	26 credits within 24 months	24 credits within 24 months
Earning Credits	Over 24 hours, but less than 48 hours in one month = 1 credit Over 48 hours per month= 2 credits	Over 24 hours, but less than 48 hours in one month = 1 credit Over 48 hours per month= 2 credits
Maximum Number of Credits that may be Accumulated (Banked)	26 credits	24 credits
Benefits	$150 per week (unemployment and jury duty) $160 per week (disability)	One month of Health Care Plan eligibility for four SHC credits
Maximum Annual Benefit	26 weeks maximum for non-disability employment 52 weeks maximum for disability	24 credits is the maximum that can be used in any year. 24 credits = 6 months of eligibility
Eligibility Requirements	1. Involuntary unemployment, AND: (a) on the out-of-work list, AND (b) receiving state unemployment benefits, AND (a) available for work. OR 2. Jury Duty (2 + days), OR 3. On Worker's Comp for occupational illness or injury, OR 4. Receiving state disability benefits for non-occupational illness or injury.	1. Hour Bank has been used up, AND 2. Eligible for subsidized self-pay, AND 3. Available for work, AND 4. Either: (a) on the out-of-work list, OR (b) used up disability eligibility rights.
Application Required?	Yes; filed with the Trust Office	No; Trust Office and Union Office determine if eligibility requirements have been met.

SUPPLEMENTAL HEALTH CARE BENEFITS

Supplemental Health Care (SHC) benefits provide a Participant working under the jurisdiction of Sheet Metal Workers' Local Union No. 104 up to six (6) months of health care coverage in any one calendar year, under the Sheet Metal Workers Local 104 Health Care Plan when his/her Reserve Hour Bank has run out. Residential Utility Workers and Maintenance Service Technicians are not eligible for this benefit.

ELIGIBILITY REQUIREMENTS

You do not need to file an application to receive Supplemental Health Care (SHC) benefits. The Trust Fund Office will send a list of individuals who qualify for SHC benefits to the Local Union, and the Local Union will review the list to verify that these individuals are on the out-of-work list.

If you become eligible for EDD benefits on or after March 16, 2020 because of "shelter in place" mandates issued by any city, county or the State of California, you will be eligible for SHC benefits. In this limited circumstance, if you provide to the Fund Office an EDD check stub with a first claim effective date of March 16, 2020 or later, you will not be required to sign the out-of-work list.

You will be initially eligible for monthly SHC benefits provided you have accumulated twenty-four (24) credits in your account based on contributions made on your behalf by a contributing Employer within a twenty-four (24) month period, and:

a. You have used all reserve eligibility benefits (hour bank hours) under the Sheet Metal Workers Local 104 Health Care Plan; and

b. You are eligible to make monthly subsidized self-payments for continued coverage under the Sheet Metal Workers Local 104 Health Care Plan; and

c. You are signed on a Sheet Metal Workers' Local Union No. 104 Dispatch Office out-of-work list and available for work, or disabled, and your disability rights pursuant to the Sheet Metal Workers Local 104 Health Care Plan have been exhausted.

WARNING

Should you retire pursuant to the terms of the Sheet Metal Workers of Northern California Pension Plan, or any other pension benefits provided by a plan within the Sheet Metal Industry, you will be required to reimburse this Plan for any payments made on your behalf to the Sheet Metal Workers Local 104 Health Care Plan for any period such payments were made on or after the effective date of your retirement (see page 79). You are also required to pay ten percent (10%) annual interest on the outstanding balance in the event repayment in full is not made within ninety (90) days of notification that repayment is required.

CREDIT ACCOUNT

A credit account will be established for each Participant for whom Employer contributions have been received by the Plan. Credits are accumulated as follows:

a. For each month you work at least twenty-four (24) hours but less than forty-eight (48) hours and your Employer has made contributions on your behalf for such months, you will be credited with one (1) eligibility credit.

b. For each month you work forty-eight (48) hours or more and your Employer has made contributions on your behalf for such months, you will be credited with two (2) eligibility credits.

The maximum number of credits that may be accumulated in your credit account is twenty-four (24).

The balance of your account will be recalculated each month to reflect credits earned and credits cancelled during the month. If you have a positive balance in your account and meet the eligibility requirements, you are able to use credits for benefits. Four (4) credits will be deducted from your credit account for each monthly SHC payment made to the Sheet Metal Workers Local 104 Health Care Plan on your behalf. For example, 4 credits equal one month of eligibility, 8 credits equal two months of eligibility, etc. The maximum number of credits available for coverage under the Sheet Metal Workers Local 104 Health Care Plan in any one calendar year is 24.

LOSS OF CREDITS

If no employer contributions were made or required to be made on your behalf for twenty-four (24) consecutive months, your entire accumulated credits are canceled and you must re-qualify for initial eligibility. However, your credits will not be canceled if contributions are not made because:

a. You are performing work under a Local 104 Collective Bargaining Agreement which does not require contributions to this Plan;

b. You have an injury or illness compensable under state Workers' Compensation laws;

c. You have an injury or illness for which you are receiving State Disability Benefits; or

d. You are serving in the Armed Forces of the United States.

AMOUNT OF BENEFITS

The amount of the SHC benefits payable for an eligible Participant is 100% of the subsidized monthly premium payable to the Sheet Metal Workers Local 104 Health Care Plan. Payment of SHC benefits will be made directly to the Sheet Metal Workers Local 104 Health Care Plan for the month(s) beginning with the month in which the Fund Office receives notification that your Reserve Hour Bank has run out and you are eligible to continue coverage under the Plan by making subsidized self-payments.

A maximum of six (6) months of payments will be made to the Sheet Metal Workers Local 104 Health Care Plan on your behalf during a benefit year (a "Benefit Year" is a calendar year—January 1st through December 31st). However, if you failed to earn 24 credits in the prior 24-month period, the maximum number of months of eligibility will be reduced—you must have at least 4 credits for one month of eligibility.

INELIGIBILITY FOR BENEFITS

You are not eligible for benefits if you meet any of the following:

a. Entitlement to a Pension. You are not eligible for benefits if you receive pension benefits under the Sheet Metal Workers of Northern California Pension Plan or any other pension benefits provided by a plan within the Sheet Metal Industry pension plan for any period in which you received benefits under this Plan.

b. Voluntary Termination of Your Employment. You are not eligible for benefits if you voluntarily terminate your covered employment.

c. Refuse Work or Unavailable for Work. You are not eligible for benefits if you refuse work covered under the Collective Bargaining Agreement or you are otherwise not available for work.

d. Entitlement to Social Security Benefits. You are not eligible for benefits if you receive Social Security benefits.

e. Denial of State Benefit Because of Labor Dispute. You are not eligible for benefits if you are denied a State-benefit based on an adjudication that you are unemployed because of a labor dispute.

f. Failure to Attend Class/Comply with JAC Rules. You are not eligible for benefits if you are a Participant of a Local 104 Apprenticeship or Training Program, and you fail to attend required regularly scheduled apprenticeship/training classes during the period of a layoff. Similarly, if you do not attend required Joint Apprenticeship Committee (JAC) classes, you are no longer eligible for benefits under the Plan.

g. Work in Non-Covered Sheet Metal Work. You are not eligible for benefits if you perform work which constitutes covered work under the Collective Bargaining Agreement for a person or entity which is not an Employer, or you engage in such work as an independent contractor, proprietor, partner or owner. Work in Non-Covered Sheet Metal Work will result in the cancellation of your entire accumulated credits.

   'Employer' shall mean any member of the Bay Area Sheet Metal and Air Conditioning Contractors National Association, or Independent Contractor Associations of any Signatory Individual Employer or any Individual Employer who has a Collective Bargaining Agreement with the Sheet Metal Workers Local 104 Union providing for the payment of Employer contributions into the Trust Fund. The term Employer shall also include the Sheet Metal Workers Local 104 Union, participating Trust Funds and Employers of apprentices whose employment is pursuant solely to an Apprenticeship Contribution Agreement.

h. Material Misrepresentation. If the Trustees determine that you engaged in a material misrepresentation in connection with your application for benefits under this Plan, or you have engaged in a willful violation of Plan rules, they have the authority to cancel all or part of your accumulated credits in your credit account. A willful violation may also cause you to become ineligible for future retiree benefits under this Plan.

APPEALS PROCEDURES

If your claim for Supplemental Health Care Benefits is denied, you may submit a written appeal to the Trustees in accordance with the procedures on page 94 of this booklet.

ERISA Information

STATEMENT OF ERISA RIGHTS

As a participant in the Sheet Metal Workers Local 104 Health Care Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants be entitled to examine, without charge, at the Trust Fund Office and at other specified locations, such as worksites and union halls, all Plan documents, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration. Copies of these documents and other Plan information may also be obtained upon written request to the Trust Fund Office; a reasonable charge may be made for the copies. Plan participants are also entitled to receive a summary of the Plan's annual financial report. The Joint Board is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage
You are entitled to 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 this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

You are entitled to a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date.

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 this Plan. The people who operate your Plan, called 'fiduciaries' of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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

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

the materials, unless the materials were not sent because of reasons beyond the administrator's control. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

NAME OF PLAN

The name of this Plan is the Sheet Metal Workers Local 104 Health Care Plan.

TYPE OF PLAN

The Sheet Metal Workers Local 104 Health Care Plan is a collectively bargained, jointly trusteed welfare Plan which provides hospital, medical, surgical, dental, vision, prescription drug, death and dismemberment, weekly supplemental unemployment benefits and monthly supplemental health care payments for continued coverage under the Sheet Metal Workers Local 104 Health Care Plan for eligible Participants.

ADDRESS AND PHONE NUMBER OF THE TRUST FUND OFFICE

Sheet Metal Workers Local 104 Health Care Plan
3240**B** Constitution Drive
Livermore, CA 94551
(925) 208-9994 or toll free (800) 548-1771

PLAN YEAR

The Plan's fiscal year ends on June 30.

IRS EMPLOYER IDENTIFICATION NUMBER

The Identification Number assigned by the Internal Revenue Service is 94-2541328.

PLAN NUMBER

501

HEALTH CARE PROVIDERS FOR THE PLAN

All of the types of benefits provided by the Plan are summarized in this booklet. Some of the benefits are provided through insurance policies or service agreements. The complete terms of the benefits provided are set forth in the group insurance policies or service agreement with the following organizations:

- **Beat It!**
  P.O. Box 20896
  San Jose, CA 95160
  (800) 828-3939
  www.beatiteap.com
  Provides insured alcohol and substance abuse benefits.

- **WellDyneRx ***
  P.O. Box 90369
  Lakeland, FL 33804
  (888) 479-2000
  www.WellDyneRx.com
  Provides managed prescription drug benefits.

- **Delta Dental ***
  100 First Street
  San Francisco, CA 94105
  (800) 422-4234
  www.deltadentalins..com
  Provides PPO dental benefits

- **Vision Service Plan***
  101 California Street, Suite 975
  San Francisco, CA 94111
  (800) 877-7195
  www.vsp.com
  Provides PPO vision exam benefit

- **Blue Shield**
  50 Beale Street
  San Francisco, CA 94105
  (800) 541-6652
  www.blueshieldca.com
  Administers PPO Network for the Indemnity Plan, as well as UR and Case Management.

- **Kaiser Permanente ***
  Northern California Region
  1800 Harrison, 13th Floor
  Oakland, CA 94612-3429
  (800) 464-4000
  www.kp.org
  Provides prepaid medical benefits with guaranteed payment of these benefits.

- **BeneSys Administrators ***
  3240B Constitution Drive
  Livermore, CA 94552
  (800) 548-1771
  www.benesysinc.com
  Administers the self-funded medical plan; does not guarantee payment of benefits.

** These providers process and pay claims and handle claims appeals related to their programs of benefits.*

PLAN ADMINISTRATOR AND SPONSOR

The Plan is sponsored and administered by the joint Board of Trustees, consisting of equal numbers of Employer Trustees and Union Trustees. The Board of Trustees has engaged BeneSys Administrators to perform certain routine administrative services as a contract administrator. The name and business address of the Trustees are:

MEMBERS OF THE BOARD OF TRUSTEES

EMPLOYER TRUSTEES	EMPLOYEE TRUSTEES
SEAN O'DONOGHUE, CO-CHAIR Bay Area SMACA 7677 Oakport Street, Suite 805 Oakland, CA 94621	**RICK WERNER, CHAIRMAN** Sheet Metal Workers Local 104 3232 Constitution Drive Livermore, CA 94551
BOB BRAMLETT Aire Sheet Metal 1973 East Bayshore Road P.O. Box 5217 Redwood City, CA 94063	**KEITH DIAS** Sheet Metal Workers Local 104 4350 Central Place, Suite B Fairfield, CA 94534
CHRIS ENFANTINO Environmental Systems, Inc. 3353 De La Cruz Boulevard Santa Clara, CA 95054	**ERIC HAYNES** Sheet Metal Workers Local 104 2350 Lundy Place San Jose, CA 95131
DUANE DAVIES National Air Balance Company, Inc. 4171 Business Center Drive Fremont, CA 94538	**RICHARD KOENIG** Sheet Metal Workers Local 104 1939 Market Street, Suite A San Francisco, CA 94103
KATHY DE JONG, Alternate Bay Area SMACNA 7677 Oakport Street, Suite 805 Oakland, CA 94621	**JOSEPH A. MARACCINI** Sheet Metal Workers Local 104 3232 Constitution Drive Livermore, CA 94551
PAUL STECKEL Van-Mulder Sheet Metal, Inc. 2437 Radley Court Hayward, CA 94545**S**	**BRIAN MASTERS** Sheet Metal Workers Local 104 3232 Constitution Drive Livermore, CA 94551
	BRIAN WERNER Sheet Metal Workers Local 104 1720 Marina Blvd. San Leandro, CA 94577
	DOMINIC TORREANO Sheet Metal Workers Local 104 2350 Lundy Pl. San Jose, CA 95131

DURATION OF PLAN

It is intended that the Plan will continue indefinitely, but the Board of Trustees reserves the right to change and/or discontinue the Plan at any time. In addition, this Plan may terminate by agreement of the participating employers and unions or by operation of law. If the Plan is terminated, its remaining assets after payment of all expenses will be used to continue to provide benefits for as long as the Plan assets permit; or else the assets will be transferred to a successor plan providing health care benefits, weekly supplemental unemployment benefits and monthly supplemental health care benefits. In no event will termination of the Plan result in reversion of any assets to contributing employers.

MAINTENANCE OF THE PLAN, CONTRIBUTIONS AND FUNDING MEDIUM

The Collective Bargaining Agreements between Sheet Metal Workers Local 104 and the various employers and employer associations require each participating employer to contribute to the Plan at a specified rate per hour for hours worked in covered employment by each of their employees. Employers may also sign participation agreements providing coverage for non-bargaining unit employees and retirees and in some cases participants or beneficiaries may be permitted to self-pay for a period of time when they are not covered by employer contributions. Assets of the Plan are held in trust and benefits are funded through the Trust Fund. All Plan benefits are provided directly from the Trust Fund, except for those provided by the Kaiser Health Plan. The Kaiser Health Plan receives premiums from the Trust Fund to provide Hospital, Medical, and Surgical benefits for those employees and their dependents who elect to be covered by that Plan. Benefits under the Kaiser Health Plan are insured by Kaiser Foundation Health Plan, Inc.

Kaiser Permanente's address is:

Kaiser Foundation Health Plan, Inc.
Northern California Region
1800 Harrison, 9TH Floor
Oakland, CA 94612
(800) 464-4000

AGENT FOR SERVICE OF LEGAL PROCESS

The Plan's agent for service of legal process is:

George M. Kraw or Lisa Schwantz
Kraw Law Group, APC
605 Ellis Street, Suite 200
Mountain View, CA 94043

Legal process may also be served on any member of the joint Board of Trustees.

DESCRIPTION OF COLLECTIVE BARGAINING AGREEMENTS AND OTHER AGREEMENTS

This booklet is a summary of benefits. The Plan contracts with other health service providers providing benefits under the Plan: the Trust Fund Office, Plan consultant, counsel, auditor and investment manager. The Trust Agreement, Collective Bargaining Agreements providing for contributions to the Plan, and all filings required by the state and federal governments are hereby incorporated by reference and are available for inspection by Plan participants and union or employer representatives at the Trust Fund Office upon reasonable notice.

A complete list of employers maintaining this Plan is available for examination at the Trust Fund Office or your local union office. A copy may be obtained upon written request to the Trust Fund Office. A charge may be made by the Trust Fund Office to provide you with this information.

RELATIONSHIP BETWEEN PLAN AND PROVIDERS OF MEDICAL SERVICES

No health care provider is an agent or representative of the Plan or of the Board of Trustees. The Plan does not control or direct the provision of health care services and/or supplies to Plan participants and beneficiaries by anyone. The Plan makes no representation or guarantee of any kind concerning the skills or competency of any health care provider. The Plan makes no representation or guarantee of any kind that any provider will furnish health care services or supplies that are malpractice-free.

The foregoing statement applies to any and all health care providers, including both preferred and non-preferred providers under the terms of the Plan. The statement also applies to all entities (and their agents, employees, and representatives) which contract with the Plan to offer preferred provider networks or other health-related services or supplies to participants and beneficiaries.

Nothing in this Plan affects the ability of a provider to disclose alternative treatment options to a participant or beneficiary.

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