

**NORTHERN CALIFORNIA SHEET METAL WORKERS  
HEALTH CARE PLAN**

Summary Plan Description

For Active Benefit Schedules 1, 1A and 2  
and Retiree Benefit Schedules 1 and 7

January 2017

## **NORTHERN CALIFORNIA SHEET METAL WORKERS HEALTH CARE PLAN**

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### **To All Participants**

The Board of Trustees of the Northern California Sheet Metal Workers Health Care Plan is pleased to provide this description of the benefits available to you.

This booklet is called a Summary Plan Description. Its purpose is to highlight the key features of the Plan as of January 1, 2017. Please note that there is not a separate "full" plan document and the Summary Plan Description and Trust Agreement are the primary "plan documents" under federal law. If you are enrolled in an HMO, such as Kaiser, the HMO's Evidence of Coverage will also serve as a plan document describing your benefits. Collective bargaining agreements, and Internal Revenue Service and Department of Labor regulations are also used to determine how the Plan operates, what benefits are paid and who is eligible to receive them. Copies of plan documents, your collective bargaining agreement and HMO Evidence of Coverage will be made available for your review by making a written request to the Trust Fund Office. You may also obtain provider lists (i.e., in-network or "preferred" doctors and hospitals) by making such a request.

If you have any questions about a particular benefit, please contact the Trust Fund Office. Only the Trust Fund Office can officially answer your questions, provided you have furnished full and accurate information concerning your situation. If you want an official written response, you must send your question, in writing, to the Trust Fund Office. You may not rely on oral representations regarding your benefits. Although the Trustees, Union Business Representatives and other people familiar with the Plan may answer questions for you, the Plan is not bound by any inaccurate information they may give.

You have certain rights, including the right to obtain information regarding your Plan, that are guaranteed under the Employee Retirement Income Security Act of 1974 (ERISA). These rights are explained in detail on page 96 of this booklet.

### **Limitation of Responsibility**

Please understand that this is not an insured plan and therefore benefits are not guaranteed.

The benefits provided by this Plan and the premiums required by Kaiser Permanente Health Plan are payable out of the Trust Fund to the extent the funds are available in the Trust Fund for that purpose. No other funds and no other person, firm, association, corporation or other entity can be liable for the payment of benefits.

The benefits established by this Plan have been adopted by the Trustees, based on the information available to them as to the cost of benefits and the contributions which they anticipate receiving under the applicable collective bargaining agreements. The Trustees reserve the right to modify benefits or eligibility rules at any time, or to reduce or even eliminate benefits, if necessary, to maintain the financial soundness of the Plan. The Trustees also reserve the right to terminate this Plan at any time.

The Trustees have the right, in their sole discretion, to interpret the terms and provisions of the Plan and this booklet, the Trust Agreement, and the rules, regulations and procedures of the Plan. Their good faith interpretations thereof are final and binding on the participants, beneficiaries, and employers.

The Trustees hope to be able to continue to offer extended coverage for retired employees and surviving family members. However, their ability to do so depends on the underlying collective bargaining agreements and economic considerations. As with benefits for all participants, retiree and survivor benefits are not pre-funded and are not "vested," so future economic conditions might require the Trustees to reduce benefits, increase your contributions, or even

eliminate the extended coverage provision of the Plan. This may occur before or after a covered person's retirement or death.

*Board of Trustees*

### **NOTE FOR SCHEDULE 2 PARTICIPANTS**

Starting in 2015, Schedule 2 no longer has a separate Summary Plan Description. If you are a Schedule 2 participant, you should refer to this booklet *and* the Schedule 2 Addendum for a complete description of your benefits. Some of the information in this booklet will not apply to your benefit plan. The Schedule 2 Addendum explains how your benefits and eligibility rules differ from the benefits described in this booklet. This booklet and the Schedule 2 Addendum together comprise your Summary Plan Description. Be sure that you have *both* this booklet and the Schedule 2 Addendum. If you have any questions about your Schedule 2 benefits, contact the Trust Fund Office.

## TELEPHONE DIRECTORY

<u>Organization</u>	<u>Website</u>	<u>Telephone No.</u>
<b>Trust Fund Office</b> Questions, Forms, plan documents, provider links	<a href="http://www.Sheet162fringe.org">www.Sheet162fringe.org</a>	(925) 208-9992 (866) 787-0162
<b>Blue Shield</b> Preferred Provider (PPO) Network – inside California	<a href="http://www.blueshieldca.com/networkppo">www.blueshieldca.com/networkppo</a>	(800) 541-6652
<b>Blue Shield</b> Preferred Provider (PPO) Network – outside California only	<a href="http://provider.bcbs.com">http://provider.bcbs.com</a>	(800) 810-2583
<b>Envision Rx</b> Retail Prescription Drug Provider	<a href="http://www.envisionrx.com">www.envisionrx.com</a>	(800) 361-4542
<b>Costco Rx</b> Mail Order Prescription Drug Provider	<a href="http://www.costco.com">www.costco.com</a>	(800) 607-6861
<b>Kaiser Permanente</b> Membership Services	<a href="http://www.kaiserpermanente.org">www.kaiserpermanente.org</a>	(800) 464-4000
<b>Medicare</b> Social Security Administration	<a href="http://www.medicare.gov">www.medicare.gov</a>	(800) 772-1213
<b>TARP</b> Substance Abuse Provider		(800) 522-8277
<b>Delta Dental</b> Dental Network	<a href="http://www.deltadentalins.com">www.deltadentalins.com</a>	(800) 548-1771
<b>Bright Now!/Newport Dental</b> Pre-Paid Dental Option		(800) 497-6453
<b>VSP</b> Vision Provider	<a href="http://www.vsp.com">www.vsp.com</a>	(800) 877-7195

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## Eligibility...

*when you and your family members are covered  
under the Plan.*

## Eligibility

Eligibility for you and your eligible family members depends on the number of hours you work in “covered employment” and your “benefit schedule.”

### **Covered Employment**

Covered employment is work you do which helps you earn coverage under the Plan. Covered employment includes the following:

- Work you do under a collective bargaining agreement between Local 104, District 2 of the Sheet Metal Workers International Association and an employer who agrees to contribute to the Plan on your behalf.
- Other types of work, including employment with Local 104, District 2, or for an employer who has signed a “Subscription Agreement” to contribute to the Plan on your behalf. A Subscription Agreement is typically used to cover non-bargained employees who work for a participating employer. 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.

### **Non-Covered Employment**

If you work in non-covered sheet metal service, you will lose your coverage under the Plan. See page 79 for details.

### **Your Benefit Schedule**

The Plan may include medical, dental, vision, substance abuse, prescription drug, life insurance and accidental death and dismemberment benefits. However, the specific benefits you and your eligible family members are eligible to receive depend on your “benefit schedule.” Generally, your collective bargaining agreement (or Subscription Agreement) states which benefit schedule applies to you. The benefit schedule for retirees is determined when you retire. Call the Trust Fund Office to find out your benefit schedule, and refer to the following chart for your benefits under this Plan.

	<b>Schedule 1 and 1A (Also Retiree Plan for Sch 1 &amp; 1A)</b>	<b>Schedule 7 Medical Only (Optional Retiree Plan for Sch 1 &amp; 1A)</b>
<b>Medical</b>	Yes	Yes
<b>Dental</b>	Yes	No
<b>Vision</b>	Yes	No
<b>Substance Abuse</b>	Yes	Yes
<b>Prescription Drug</b>	Yes	No
<b>Life Insurance</b>	Yes	Yes
<b>Accidental Death &amp; Dismemberment</b>	Yes	Yes
<b>Dependent Eligibility</b>	Yes	Yes

## 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, 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 sufficient documentation is received by the Plan enabling the dependent to be enrolled.** The next opportunity to switch plans will be after 12 months.

#### Enrolling New Dependents

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

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, 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. *Please note: If you acquire a dependent who is eligible for Medicare and enrolls in Kaiser Permanente Senior Advantage (KPSA), coverage will be retroactive to the first of the month in which the enrollment form is received. This is because KPSA cannot provide retroactive coverage beyond 30 days.*

**Claims for dependents cannot be processed until an enrollment form and proper documentation are received by the Trust Fund Office.**

#### Notification of Change of Address

From time to time, the Trust Fund Office will need to write to you to inform you of changes in the Plan adopted by the Trustees or about information related to your benefits.

In these instances, the Plan will try to make sure that you receive the written notices. However, if you move or change your mailing address or if you think the Trust Fund Office does not have your current address, you must notify the Trust Fund Office, in writing, of the change of

address immediately. The Plan and the Trustees cannot be held liable for not keeping you informed if you change your address and do not notify the Trust Fund Office in a timely manner.

#### 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.

## **Your Eligible Family Members**

Your eligible family members are:

- Your legal husband or wife, provided you are not divorced or legally separated.
- If you divorce, your former spouse is no longer an eligible family member on the date of the final divorce decree. If you legally separate, your spouse is no longer an eligible family member as of the effective date of the legal separation.

*You must notify the Trust Fund Office immediately but no later than 30 days of your divorce or legal separation. If you do not timely notify the Trust Fund Office of your divorce or legal separation and the Fund pays benefits on your former spouse's behalf, you may be responsible for reimbursing any overpayments to the Plan and the Plan may withhold benefit payments that would otherwise be payable on behalf of you or your family until it has recouped any overpayments.*

- Your children under age 26. For purposes of this Plan, your children can include:
  - your natural children,
  - your legally adopted children (from the time they are placed in your home),
  - your stepchildren, or
  - children for whom you have been appointed legal guardian by a court.

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

If you are required to pay the medical expenses of a dependent due to a Qualified Medical Child Support Order (QMCSO), the Trust may enroll the dependent in the Plan even if you do not submit an enrollment form. The Trust Fund Office must determine that the QMCSO is qualified under the terms of ERISA and applicable state law. A complete description of the Plan's QMCSO procedures may be obtained from the Trust Fund Office.

- 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.
- Your Disabled Dependent, after the death of the covered employee or surviving spouse, who may be covered as a separate individual if certain criteria are met (see page 73 for details).

### ***Enrolling Your Eligible Family Members***

Your eligible family members may be covered only within the following time periods:

1. During the month in which you make your first payment for your own coverage under the Plan.
2. Within 30 days of the date your spouse or child loses coverage under your spouse's group health plan. You must submit evidence that your spouse or child was (and no longer is) covered under your spouse's plan.
3. At any time you acquire a new family member – such as through marriage, birth or adoption (normally effective the first day of the month in which the enrollment form with appropriate documentation, i.e. marriage or birth certificate, is received by the Trust Fund

Office). Although new dependents born to you are automatically eligible at birth, claims for them will be held pending receipt of enrollment form and documentation.

**Important:** You can be held liable for benefit payments made based on any incorrect information about your family members, such as failing to notify the Trust Fund Office if there is a divorce or legal separation, 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.

### **Qualifying Period For Coverage To Begin**

The qualifying period is a minimum number of hours you must work and a minimum period of time which must pass before you will be covered under the Plan.

You will need to meet the qualifying period if you are a new employee or if your eligibility under the Plan has lapsed for 12 or more consecutive months. Refer to page 5 and below for details on eligibility.

#### *Minimum Qualifying Period Hours...*

You and your eligible family members will be covered under the Plan after you have worked the “minimum qualifying period hours.” The Trust Fund Office keeps track of your hours by using a “Reserve Hour Bank.” Each hour that you work in covered employment is credited as one hour in the bank, provided your employer makes the required contribution. See page 8 for a description of what happens if your employer fails to make contributions.

The requirements you must meet before your Plan coverage begins depend on your benefit schedule. Contact the Trust Fund Office to find out which benefit schedule applies to you. Refer to the chart below for the minimum qualifying period hours you need to work before your coverage begins.

#### *To Qualify For Coverage...*

	<b>Schedule 1</b>	<b>Schedule 1A</b>
<b>Minimum Qualifying Period Hours</b>	120 hours	260 hours
<b>Minimum Qualifying Period</b>	1 month	2 months
<b>Coverage Begins</b>	3 <sup>rd</sup> month	4 <sup>th</sup> month

#### *Minimum Qualifying Period...*

Regardless of how many hours you work, your “qualifying period” will not be over until the minimum qualifying period of time has passed and your employer has made the contributions on your behalf. This minimum qualifying period depends on the benefit schedule that applies to you. Refer to the chart above for your minimum qualifying period.

If Benefit Schedule 1 applies to you, your qualifying period will be met when you are credited with 120 hours and you have worked a minimum of one calendar month.

If Benefit Schedule 1A applies to you, your qualifying period will be met when you are credited with 260 hours and you have worked a minimum of two calendar months. Even if you work 260 hours within a one-month period, you will not have met your qualifying period until you have worked for two calendar months.

### **Maximum Qualifying Period...**

There is also a time limit of 11 consecutive months in which you must accumulate all of your qualifying period hours. If you fail to accumulate the qualifying period hours within the 11-month period, you lose all of the hours in your Reserve Hour Bank and you must begin a new 11-month period and requalify.

### **When Your Coverage Begins – The “Lag” or “Skip” Month Requirement**

After you meet all the qualifying period requirements, there is a “lag month” before coverage begins for you and your eligible family members. Your coverage begins on the first day of the second month after you satisfy the qualifying period.

Here’s an example of how the “lag month” requirement works:

<b>Benefit Schedule</b>	<b>Qualifying Period Requirements Met</b>	<b>Lag Month</b>	<b>Coverage Begins</b>
<b>Schedule 1</b>	May	June	July 1
<b>Schedule 1A</b>	May/June	July	August 1

**Note:** This example shows how the “lag month” requirement generally works. Your particular case may be different.

As this chart shows for example, if you are covered under Benefit Schedule 1 and meet your qualifying period requirement at the end of May, your coverage will begin on the first day of July.

For your first month of coverage, the total qualifying hours will be deducted from your Reserve Hour Bank. For example, assume you are eligible for coverage under Benefit Schedule 1 and you complete your qualifying period with 130 hours in your Reserve Hour Bank. For your first month of Plan coverage, 120 hours will be deducted from your Reserve Hour Bank, leaving you with a balance of 10 hours.

For another example, assume you are eligible for coverage under Benefit Schedule 1A and you complete your qualifying period with 320 hours in your Reserve Hour Bank. For your first month of Plan coverage, 260 hours will be deducted from your Reserve Hour Bank, leaving you with a balance of 60 hours.

For future months, see “Maintaining Your Coverage,” described below.

### **Forms to Be Completed By Newly Eligible Participants**

Under standard procedures, you will complete an Enrollment/Beneficiary Card received from the Trust Fund Office when you gain eligibility under this Plan. If you have not completed such a card or wish to change your beneficiary, please call the Trust Fund Office.

### **Maintaining Your Coverage**

For each month you are covered under the Plan, the Trust Fund Office will withdraw a certain number of hours from your Reserve Hour Bank. The number of hours depends on your benefit schedule. Keep in mind that there is a one month lag from the time you accrue your hours to the time you receive coverage. Refer to the chart below for the hours required for each month of coverage in the benefit schedule that applies to you.

*To Maintain Coverage...*

	Schedule 1	Schedule 1A
<b>Hours Required for 1 Month of Ongoing Coverage</b>	120 hours	130 hours
<b>Maximum Reserve Hours</b>	480 hours (4 months)	260 hours (2 months)

For example, assume Benefit Schedule 1 applies to you and that you last worked during the month of November. At the end of November, you had 265 hours in your Reserve Hour Bank. From your November balance, 120 hours will be withdrawn from your Reserve Hour Bank for January coverage, leaving you with a balance of 145 hours. Then, another 120 hours will be withdrawn from your Reserve Hour Bank for February coverage, leaving you with a balance of 25 hours.

In order to remain covered under the Plan, each month you will need to have enough hours in your Reserve Hour Bank to cover the amount withdrawn by the Trust Fund Office. Using the above example, unless you are credited with 95 more hours by the end of January, your coverage will end on February 28, because you do not have enough hours in your Reserve Hour Bank for March coverage. (However, you may be eligible to continue your benefits by paying for them yourself under COBRA or self pay.)

There is a maximum number of hours you can accumulate in your Reserve Hour Bank. That maximum depends on the benefit schedule that applies to you, as shown in the chart above.

**If Your Reserve Hours Fall Below The Minimum Hours Required**

If your Reserve Hour Bank falls below the minimum hours required for one month of ongoing coverage, your coverage will end on the last day of the following month. You can re-qualify for coverage if you bring the Reserve Hour Bank back up to the minimum required level within 11 months after your eligibility ends. The Trust Fund Office will then withdraw enough hours to provide you with eligibility for the second month following the month in which your Reserve Hour Bank reaches the required level.

If you do not bring your Reserve Hour Bank back up to the required level within 11 months after your eligibility ends, any remaining hours in your Reserve Hour Bank will be forfeited and you will have to re-qualify in the same manner as a new employee.

**Cost Of Coverage**

For each hour that you work, your employer contributes toward the cost of your coverage. The amount that your employer contributes is based on your collective bargaining or Subscription Agreement. Under the Subscription Agreement, contributions may be determined by the agreement and not by the actual hours you work.

**If Your Employer Fails To Make Contributions To The Plan**

If your employer's contributions on your behalf are not received within two months after they are due, you should notify the Trust Fund Office. If your employer fails to make contributions for a six-month period, you will stop accruing hours in your Reserve Hour Bank for the next six months, and your coverage may be jeopardized.

## **Disenrollment From Vision and Dental Coverage**

In order to comply with the Affordable Care Act, the Plan is required to allow you and your dependents to disenroll from your vision and dental coverage. You may only disenroll from vision or dental coverage if you have not changed your coverage within the past twelve (12) months. Please note that except in very rare circumstances, disenrolling from vision or dental coverage will not be in your best interest. Your employer's monthly contribution for coverage (or your self-pay rate) will not be reduced. After you disenroll, you will not be able to re-enroll in vision or dental coverage for twelve (12) months. Please call the Trust Fund Office to discuss whether disenrolling from vision or dental coverage makes sense for you.

## **Special Enrollments/Notice of Employee Rights**

Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, if you decline enrollment for yourself or your dependents (including your spouse and eligible children) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after you lose that coverage. This loss of coverage must be because (1) you or your dependents are no longer eligible, (2) employer contributions are terminated, or (3) COBRA coverage is exhausted. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you will be able to enroll yourself and your dependents prospectively (see page 3).

## **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.

The Plan has entered into reciprocity agreements with all 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.

If you have any questions about reciprocity, call the Trust Fund Office.



## Medical Benefits...

*to help you pay the cost of necessary medical expenses resulting from non-employment related illnesses or injuries.*

## **Your Medical Benefits**

The medical coverage portion of the Northern California Sheet Metal Workers Health Care Plan is designed to help pay many of the health care expenses for you and your covered family members.

The Plan provides an outstanding level of financial protection:

- For Schedules 1, 1A and 7, the Plan offers an unlimited calendar year and unlimited lifetime benefit protection for you and each of your covered family members.
- The Plan also protects you from paying large amounts of certain eligible expenses out of your pocket. For Schedules 1 & 7, it covers 100% of those remaining eligible expenses during the rest of any calendar year in which your out-of-pocket costs for those expenses reaches \$5,150 single/ \$5,300 family. For Schedule 1A it covers 100% of those remaining eligible expenses during the rest of any calendar year in which your out-of-pocket costs for those expenses reaches \$5,225 single plus \$250 for each additional family member up to \$5,900 maximum per family.

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 pays only 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. See page 34 for a list of other expenses not paid by the Plan.
- The Plan pays only 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 at (800) 541-6652. See page 15.
- The Plan pays benefits based on what it considers a "Usual, Customary and Reasonable" charge. The charges above this level are not covered. See page 13.
- The Plan pays a percentage or maximum dollar amount of certain charges, as outlined in the benefits set forth in the chart on page 12 and as detailed more completely in pages 19 through 33. Anything over that percentage or maximum becomes your responsibility to pay. For example, the Plan pays a maximum of \$32 for a chiropractic visit. Anything over that is your responsibility. If it pays 80% of reasonable and customary charges for a visit to a contract doctor, you would pay the remaining 20% (subject to the annual deductible and out-of-pocket limits set forth on the following pages).

The Plan does not pay for expenses which are paid by some other source or are specifically excluded as listed on page 34.

## **Indemnity Plan Benefit Summary**

The Health Care Plan helps pay eligible expenses each calendar year. For more details, see the pages which follow the charts.

The following chart summarizes your medical benefits.

INDEMNITY PLAN MEDICAL BENEFITS	
Benefit	Schedules 1, 1A & 7
Annual Cash Deductible	Schedule 1, 7 — \$150 per person, \$300 family Schedule 1A — \$225 per person, \$900 per family
PPO Hospitals	80% of contract rate
Non-PPO Hospitals	60% of Usual, Customary & Reasonable (UCR), after \$200 per admission non-contract deductible, if applicable
Outpatient pre-Admission Testing	100% within 2 days of admission
Doctor's Charges – PPO	80% of contract rate
Doctor's Charges – Non-PPO	60% of Usual, Customary & Reasonable
Second Opinion	100% if referred by Blue Shield; Non-PPO not covered
Skilled Nursing Facility – PPO	80% of contract rate
Skilled Nursing Facility – Non-PPO	60% of contract rate (120 day maximum)
Chiropractic and Chiropractic X-Rays	\$32 per visit (one per day) up to \$640 annual max
Routine Physical Exam and Additional Diagnostic Procedures – PPO	100% of contract rate, exams not qualifying as preventive services are subject to applicable coinsurance, co-pays and deductibles
Routine Physical Exam and Additional Diagnostic Procedures – Non-PPO	Not covered
Acupuncture	\$41 per treatment up to \$410 per year
Custom Foot Orthotics	80% of contract rate (60% of UCR non-PPO)
Hearing Aids	80% of UCR, one aid per ear every 3 years
X-Ray and Laboratory	80% of contract rate (60% of UCR non-PPO)
Mental Health Treatment – PPO	Inpatient/Outpatient, 80% of contract rate
Mental Health Treatment - Non-PPO	Inpatient/Outpatient, 60% of UCR
Diagnostic and Therapy Services (Page 23)	80% of contract rate (60% of UCR non-PPO)
Medical Supplies and Services (Page 24)	80% of contract rate (60% of UCR non-PPO)
Home Health Care	80% of contract rate (60% of UCR non-PPO)

The chart does not include prescription drug (see page 38), dental (see page 46), substance abuse (see page 49), vision (see page 51), or death (see page 57) benefits.

**Out-of-Pocket Maximum:**

For Schedules 1 & 7: In a calendar year, if the amount you pay for certain eligible expenses (see page 19) reaches \$5,150 single/ \$5,300 family, the Plan pays 100% of any of those additional eligible expenses for that year. Charges you pay to a doctor, hospital or facility not in the Preferred Provider Network if a Preferred Provider was available to you will not count toward the out-of-pocket maximum.

For Schedule 1A: In a calendar year, if the amount you pay for certain eligible expenses (see page 19) reaches \$5,225 single plus \$225 for each additional family member up to \$5,900 maximum per family, the Plan pays 100% of any of those additional eligible expenses for that year. Charges you pay to a doctor, hospital or facility not in the Preferred Provider Network if a Preferred Provider was available to you will not count toward the out-of-pocket maximum.

**How Your Medical Benefits Work**

The Plan helps you pay each covered person's eligible expenses which are:

- medically necessary,
- prescribed by a doctor,
- within the reasonable and customary limits, and
- covered by the Plan.

For the most part, you can see any doctor and receive treatment at any hospital that you choose. However, the Plan utilizes a Preferred Provider Organization (PPO) – Blue Shield for medical care which extends reduced rates to the Plan. Besides receiving the benefits of these reduced rates, the Plan also pays a higher percentage of the cost of many services for PPO network providers than for non-PPO (non-network) providers. Thus, you will almost always pay more from your own pocket when you use a non-network provider, so you are encouraged to use PPO providers whenever possible.

**Eligible Expenses**

The Plan helps pay eligible expenses that are determined by the Trust Fund Office to be all of the following:

**Medically Necessary** as defined on page 106.

**Prescribed By A Doctor** who is a licensed practitioner of medicine or surgery who is acting within the scope of his or her practice and license.

**Usual, Customary and Reasonable (UCR)** as defined on page 109. If you would like to know the exact UCR amount for a treatment, service or supply you need, you must submit a written request to the Trust Fund Office.

When you use a contract hospital or a preferred doctor, the eligible expenses are based on a special negotiated rate which is always within the reasonable and customary limit. However, when you use a non-PPO provider, the Plan will not always pay benefits equal to or based on the provider's actual charge for health care services or supplies, even after you have paid the applicable deductible, copay and/or coinsurance. This is because unless otherwise provided, the Plan covers only the UCR amount for health care services or supplies. Any amount in excess of the UCR amount does not count toward the Plan's annual out-of-pocket maximum. You are responsible for paying any billed amounts that exceed UCR amounts.

Additionally, the Plan reserves the right to negotiate with a non-PPO provider to reduce their billed charges to a lower, discounted amount. Such negotiation may be performed by the Trust Fund Office or a designee. A designee may include, but is not limited to, a utilization

management company, claims administrator, attorney, stop loss carrier, medical claim repricing firm, discount negotiation firm or wrap/secondary network. This negotiated discounted amount will serve in lieu of the UCR amount upon which the Plan will base its payment for covered services for the non-PPO provider considering the Plan's cost-sharing provisions, in-network/non-network plan design, and any special reimbursement provisions adopted by the Plan.

**Covered By The Plan.** Many of the services and supplies determined by the Plan to be not covered are listed on pages 34-36 and throughout this booklet.

## Cost Containment Features

### **The Blue Shield Program**

When your doctor recommends overnight hospitalization or certain other covered services (see below), you should contact Blue Shield, the Plan's Utilization Review (UR) program. *If you fail to contact Blue Shield as outlined below, the Plan reduces its payment for hospital expenses by 20%.*

**Blue Shield of California, an independent member of the Blue Shield Association, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.**

**Please be aware that just because Blue Shield authorizes a procedure as medically necessary, it does not mean that the procedure will be covered by the Plan. Please refer to this booklet for a description of covered benefits, or contact the Trust Fund Office for verification of coverage.**

**Hospitalization.** You should contact Blue Shield immediately if you or a covered family member needs to be hospitalized. The phone number to call is (800) 541-6652.

**You must call Blue Shield within the following time limits:**

- When it is **not** an emergency — three working days before hospital admission that requires an overnight stay in the hospital or before the covered service requiring preauthorization.
- When it **is** an emergency — within 48 hours after emergency hospital admission that results in an overnight stay in the hospital.

*Failure to call Blue Shield within the time limits set forth above will cause the Plan to reduce its payment for hospital expenses by 20%, for which you will likely be billed.*

### **What Blue Shield Does**

When you call, Blue Shield will:

- Review the proposed treatment plan based on your medical condition.
- Determine the initial length of the hospital stay, in consultation with your doctor, which meet the guidelines under Blue Shield.
- Be available to discuss other options available under the Plan which may reduce your out-of-pocket expenses, such as pre-admission testing, outpatient surgery and treatment in a skilled nursing facility.
- Follow-up during your hospital stay to determine whether your situation has changed or to see if other types of care would meet the guidelines.

You and your doctor will be informed, by Blue Shield, whether the treatment appears to meet the program's guidelines. However, this does not assure that benefits will be paid. As with all coverage, the benefits will be determined by the provisions of the Plan. For example, benefits may not be paid — or may be reduced — if:

- you or your family member is not eligible for coverage when the treatment is provided.
- the services or treatments are not considered eligible expenses or they exceed a benefit limit.
- the information provided to Blue Shield was incorrect.

- the specific course of treatment or hospital stay that was submitted to the program was not the course that was followed.
- the coverage is for one of your covered family members and the Plan may not be required to pay benefits before other coverage pays — see “Non-Duplication of Benefits” on page 81.

**Other Covered Services.** You must call Blue Shield (within the time limits described below) to preauthorize the following covered services. The number for Blue Shield is (800) 541-6652.

- Organ transplants
- Skilled nursing facility care
- Hospice care
- Anything the Trust 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.

## **Preferred Provider Network**

The Board of Trustees has retained Blue Shield to manage the Northern California 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 Northern California Sheet Metal Workers participants and their eligible dependents.

### **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 12 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](http://www.blueshieldca.com/networkppo) or call the Trust Fund Office at (925) 208-9992 or (866) 787-0162.**

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 – BlueCard Program**

If you reside or travel outside the state of California, you will have access to providers who participate in a “Host Plan” that participates in the BlueCard Program. When you use a Host Plan provider, the Plan will pay up to 80% of the contract rate; however, if you use a hospital or physician which is *not* in the Host Plan, the Plan will pay only 60% of Usual, Customary and Reasonable charges. Please see the Out of Area Programs appendix on page 110 for additional information about coverage outside of California.

**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 <http://provider.bcbs.com> and enter the alpha prefix SEO when searching, or call Blue Card Access at (800) 810-2583.

## **How to Use the Preferred Provider Network in California**

Each time you need medical care, you may choose any doctor or facility in the Preferred Provider Network in California. 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 Northern California Sheet Metal Workers Health Care Plan and you are using the Preferred Provider Network managed by the Blue Shield.
2. When you receive treatment or services, do not pay the doctor or hospital – the provider will bill the full amount for their services directly to the Trust Fund. The Trust Fund will inform you of any expenses you must pay by sending you an Explanation of Benefits.
3. Your Explanation of Benefits will indicate:
  - (a) Any eligible expenses you are required to pay the provider.
  - (b) Expenses the Northern California Sheet Metal Workers 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.
5. If you have any questions or comments regarding your visit to a provider, or about expenses charged to you, call the Trust Fund Office.

## **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 out-of-pocket cost will be substantially less.

When you use a contract hospital, the Plan will pay 80% of the negotiated rate for hospital services, subject to Utilization Review (see page 15). You will pay the remainder, up to your out-of-pocket maximum (see page 20).

If you do not use a contract hospital, there will be a \$200 deductible (see page 20 for more information), and the Plan will pay 60% of usual customary and reasonable (UCR) charges, subject to Utilization Review. You will pay the remainder, and those payments will not count toward your out-of-pocket maximum.

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 affect your out-of-pocket costs.*

### **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 60% of UCR charges, subject to Utilization Review.

## Description of Covered Medical Services

### Annual Cash Deductible

For Schedule 1 participants, there is a \$150 per person deductible each year before the Plan begins to pay benefits. For Schedule 1A, there is a \$225 per person deductible. Any non-contract hospital deductible and any penalty for not using the Utilization Review program do not count toward satisfying the deductible.

The deductible applies separately to you and each of your covered family members. However, the Plan includes two features that may help reduce your deductible expenses for the year: the family maximum and the annual carryover.

1. **Family Maximum** – Although the annual deductible applies separately to each person, it is limited to a \$300 annual maximum for each family for Schedule 1 and \$900 per family for Schedule 1A. The following example illustrates how this works for Joe and his family. Joe is in Schedule 1:

<u>Family Members</u>	<u>Eligible Expenses</u>
Joe	\$200 (only \$150 counts toward the deductible)
Wife Sally	\$ 80
Daughter Sue	\$ 65
Son Frank	\$ 70
Daughter Linda	\$ 15

This family has met its deductible family maximum. As you can see, no more than \$150 in eligible expenses for any person can be applied toward the family maximum, but not everyone needs to satisfy it individually. The Plan helps pay all the covered family members' eligible expenses that occur after the family maximum has been met.

2. **Annual Carryover** – Any eligible expenses you have in November or December that are applied toward the deductible for that year are carried over and also applied toward the deductible for the next year. This way, if you have deductible expenses in the last two months of a year, you will be credited for them in the following year.

### 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 through Blue Shield.

**If the UR Program is not used, plan benefits may be reduced by 20%, or denied altogether if deemed not Medically Necessary.** Routine newborn charges at contract hospitals are included with the mother's negotiated rate.

2. If you use a non-PPO hospital, the Plan will pay hospital room and board and miscellaneous hospital charges at a rate of 60% of UCR, subject to Utilization Review. This benefit is also available to an organ transplant donor on your behalf.

Outpatient surgery may be performed at a hospital, surgical center or free-standing surgical center. If you use a non-PPO hospital for outpatient treatment, each year you pay a \$200 non-PPO hospital deductible, unless it is an "emergency" or meets the other conditions described below.

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

Each year you choose to use a non-PPO hospital, you pay a \$200 non-PPO hospital deductible. This applies separately to each covered family member. The annual \$200 non-PPO hospital deductible will *not* apply if:

- Your treatment is for an emergency as defined on page 104, or
- You live more than 30 miles away from a contract hospital, or
- No contract hospital within 30 miles of your home provides the services you need, or
- The only services you receive are x-ray and laboratory services as an outpatient (and not in the emergency / operating room of the hospital).

Personal items such as television rental or guest meals are not covered by the Plan.

**Emergency admissions** are treated and payable as contract hospital admissions. The Plan covers emergency services provided in a hospital emergency room without prior authorization. The Plan currently covers 80% of the contract rate for emergency services received from a PPO provider, and 80% of the Usual, Customary and Reasonable charges for emergency services received from a non-network provider. Effective January 1, 2011, the Plan has adopted a payment formula required by the Affordable Care Act that will pay non-PPO hospitals at least as much as what it would pay a PPO hospital for the same covered emergency services. The Plan's payment to the provider of emergency services will usually be 80% of the contract rate (if PPO) or the Usual, Customary and Reasonable rate (if not PPO) for those services. However, a hospital's billed charges frequently far exceed the Usual, Customary and Reasonable rates for those services. If you obtain emergency services from a non-PPO hospital, that hospital may still bill you directly for its charges that exceed what the Plan pays the hospital on your behalf (aka "balance billing"). You can avoid balance billing and will generally have lower out-of-pocket costs if you receive emergency services from a PPO hospital.

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

### **Out-Of-Pocket Maximum**

For Schedules 1 & 7:

The Plan limits your share of eligible out-of-pocket expenses to \$5,150 single/\$5,300 family each calendar year

For Schedule 1A:

The Plan limits your share of eligible out-of-pocket expenses to \$5,225 single plus \$225 for each additional family member up to \$5,900 maximum per family calendar year.

The Maximum does *not* include the following:

1. Expenses relating to the elective 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 above the dollar and day limits stated in the chart on page 12.
5. Any expenses for services related to: chiropractic care, acupuncture, foot-care, hearing aids and speech therapy for developmental delays.
6. Any dental or vision expenses.
7. Any prescription drug expenses for brand name drugs where a medically appropriate generic or Preferred Drug alternative is available or non-preferred drugs where a medically appropriate preferred drug is available (unless the Plan has made an exception because there is no medically appropriate drug available on the formulary).
8. Any expenses which are not eligible expenses under the Plan.

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

### **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 (800) 541-6652.

### **Home Health Care**

Home Health Care is covered, up to 80% of the contract rate if you use a PPO provider, or 60% of UCR for non-PPO providers, for Schedules 1, 1A and 7, subject to preauthorization. Custodial care and services delivered by a member of the patient's family are not covered by the Plan.

## 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 are limited to \$10,000 per patient, up to six months from the date of certification of a terminal illness. 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, provided they are organized and operated in accordance with applicable laws. **Admission to a Skilled Nursing Facility requires pre-authorization.**

For PPO providers, the Plan pays benefits at 80% of the negotiated rate for room and board. For non-PPO providers, the Plan pays at 60% of UCR for room and board up to 120 days per calendar year.

Miscellaneous charges at a Skilled Nursing Facility are covered at 60% of UCR, provided they meet all other Plan rules for eligible expenses and are not for custodial care.

## 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. The fees of an anesthesiologist are paid at 80% of UCR regardless of whether he or she is a PPO or non-PPO provider, as long as the surgeon and hospital are PPO providers. The services of an Assistant Surgeon, Physician Assistant, and Registered Nurse as First Assistant (R.N.F.A.) are paid, subject to UCR limits, as follows:

The Assistant Surgeon is paid up to 17% of the primary surgeon's fees, and the Physician Assistant and R.N.F.A. are paid up to 14% of the primary surgeon's fees, if the primary surgeon is a PPO provider.

The Assistant Surgeon is paid up to 15% of the primary surgeon's fees, and the Physician Assistant and R.N.F.A. are paid up to 13% of the primary surgeon's fees, if the primary surgeon is a non-PPO provider.

Fees charged by surgeons and physicians who are non-PPO are paid at 60% of UCR charges. In addition, the services of non-PPO physicians, surgeons and assistant surgeons, as well as any lab work or diagnostic testing, rendered in an emergency as defined by the Plan, will be paid up to 80% of UCR regardless of whether the provider or hospital was PPO or non-PPO, if the patient was admitted to the hospital.

## **Chiropractic Care**

The chiropractic benefit is limited to a maximum of \$640 per person each calendar year. The Plan pays 100% of the contract rate up to \$32 for each office visit (limited to 1 per day), 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.

## **Routine Physical Exam**

To encourage preventative health care, the Plan pays for routine physical examinations provided by a doctor of medicine or doctor of osteopathy, including gynecological examinations and, if required, electro-cardiograms.

### ***For Schedules 1, 1A and 7:***

Routine Physical Exams are covered at 100% of covered charges at a PPO facility. Non-preferred providers are not covered. The following limits apply:

The Plan will cover the following preventive services without you having to pay copayment or coinsurance or meet your deductible, when these services are delivered by a network provider and are recommended for your age and gender by the U.S. Preventive Services Taskforce:

You can get more information, including a list of current recommended preventive services by visiting: <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>

### **Covered Preventive Services for Adults:**

- **Abdominal Aortic Aneurysm** one-time screening for men of specified ages who have ever smoked
- **Alcohol Misuse** screening and counseling
- **Aspirin** use for men and women of certain ages
- **Blood Pressure** screening for all adults
- **Cholesterol** screening for adults of certain ages or at higher risk
- **Colorectal Cancer** screening for adults over 50
- **Depression** screening for adults
- **Type 2 Diabetes** screening for adults with high blood pressure
- **Diet** counseling for adults at a higher risk for chronic disease
- **HIV** screening for all adults at higher risk
- **Immunization** vaccines for adults –doses, recommended ages, and recommended populations vary:
  - Hepatitis A
  - Hepatitis B
  - Herpes Zoster
  - Human Papillomavirus
  - Influenza (Flu Shot)
  - Measles, Mumps, Rubella
  - Meningococcal

Pneumococcal

Tetanus, Diphtheria, Pertussis

Varicella

- **Obesity** screening and counseling for all adults
- **Sexually Transmitted Infection (STI)** prevention counseling for adults at higher risk
- **Tobacco Use** screening for all adults and cessation interventions for tobacco users
- **Syphilis** screening for all adults at higher risk

#### **Covered Preventive Services for Women, Including Pregnant Women:**

- **Anemia** screening on a routine basis for pregnant women
- **Bacteriuria** urinary tract or other infection screening for pregnant women
- **BRCA** counseling about genetic testing for women at higher risk
- **Breast Cancer Mammography** screenings every 1 to 2 years for women over 40
- **Breast Cancer Chemoprevention** counseling for women at higher risk
- **Breastfeeding** comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women
- **Cervical Cancer** screening for sexually active women
- **Chlamydia Infection** screening for younger women and other women at higher risk
- **Contraception** Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
- **Domestic and Interpersonal violence** screening and counseling for all women
- **Folic Acid** supplements for women who may become pregnant
- **Gestational diabetes** screening for women 24 to 48 weeks pregnant and those at high risk of developing gestational diabetes
- **Gonorrhea** screening for all women at higher risk
- **Hepatitis B** screening for pregnant women at their first prenatal visit
- **Human Immunodeficiency Virus (HIV)** screening and counseling for sexually active women
- **Human Papillomavirus (HPV) DNA Test** high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
- **Osteoporosis** screening for women over age 60 depending on risk factors
- **Rh Incompatibility** screening for all pregnant women and follow-up testing for women at higher risk
- **Tobacco Use** screening and interventions for all women, and expanding counseling for pregnant tobacco users
- **Sexually Transmitted Infections (STI)** counseling for sexually active women
- **Syphilis** screening for all pregnant women or other women at increased risk
- **Well-woman visits** to obtain recommended preventive services

### **Covered Preventive Services for Children:**

- **Alcohol and Drug Use** assessments for adolescents
- **Autism** screening for children at 18 and 24 months
- **Behavioral** assessments for children of all ages (Covered services vary for ages 0-17)
- **Blood Pressure** screening for children
- **Cervical Dysplasia** screening for sexually active females
- **Congenital Hypothyroidism** screening for newborns
- **Depression** screening for adolescents
- **Developmental** screening for children under age 3, and surveillance throughout childhood
- **Dyslipidemia** screening for children at higher risk of lipid disorders
- **Fluoride Chemoprevention** supplements for children without fluoride in their water source
- **Gonorrhea** preventive medication for the eyes of all newborns
- **Hearing** screening for all newborns
- **Height, Weight, and Body Mass Index** Measurements for children
- **Hematocrit or Hemoglobin** screening for children
- **Hemoglobinopathies** or sickle cell screening for newborns
- **HIV** screening for adolescents at higher risk
- **Immunization** vaccines for children from birth to age 18—doses, recommended ages, and recommended populations vary:
  - Diphtheria, Tetanus, Pertussis
  - Haemophilus influenzae type b
  - Hepatitis A
  - Hepatitis B
  - Human Papillomavirus
  - Inactivated Poliovirus
  - Influenza (Flu Shot)
  - Measles, Mumps, Rubella
  - Meningococcal
  - Pneumococcal
  - Rotavirus
  - Varicella
- **Iron** supplements for children ages 6 to 12 months at risk for anemia
- **Lead** screening for children at risk of exposure
- **Medical History** for all children throughout development
- **Obesity** screening and counseling

- **Oral Health** risk assessment for young children
- **Phenylketonuria (PKU)** screening for this genetic disorder in newborns
- **Sexually Transmitted Infection (STI)** prevention counseling and screening for adolescents at higher risk
- **Tuberculin** testing for children at higher risk of tuberculosis
- **Vision** screening for all children

### **Acupuncture Treatment**

The Plan pays covered expenses at 100% of UCR, up to a maximum of \$41 per visit (limited to 1 per day), and \$410 per calendar year. Treatments must be administered by a licensed acupuncturist, and your medical doctor or doctor of osteopathy recommends acupuncture (in writing) to treat an accidental injury or illness and acupuncture is consistent with the customary treatment for your condition.

### **Routine Podiatry (Foot) Care**

The Plan pays 80% for PPO providers (60% for non-PPO). 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. Shoes, boots or “off-the-shelf” appliances are not covered. Services must be provided by an M.D., D.P.M. or D.O for benefits to be covered.

### **Hearing Aids (Indemnity and Kaiser Participants)**

The Plan pays expenses for hearing aids, when prescribed by a physician or licensed audiologist, at 80% of UCR, up to \$2,000 for the first aid and \$1,000 for the second aid, for no more than one aid per ear every 3 years. Rather than purchase a new hearing aid, you can repair your existing aid and the Plan will pay up to the same limit. If you are a Kaiser participant, your exam is covered through the Kaiser HMO Plan.

### **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 PPO provider. Non-PPO providers are paid at 60% of UCR charges.

### **Mental Health Care (Inpatient and Outpatient)**

The Plan pays benefits 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 therapist.

#### ***Inpatient Mental Health Care***

The Plan pays up to 80% of the contract rate for PPO providers. Non-preferred providers are paid at 60% of UCR charges. You must contact Blue Shield for preauthorization (see page 15 for details).

#### ***Outpatient Mental Health Care***

The Plan pays up to 80% of the contract rate for PPO providers. Non-preferred providers are paid at 60% of UCR charges.

## Diagnostic and Therapy Services

The following items are paid at 80% of the contract rate for PPO providers, and 60% of UCR charges for non-PPO providers.

1. **X-ray, radium and radioactive isotope therapy.**
2. **Outpatient physical therapy** – (precertification required beyond 20 sessions per condition or course of treatment).
3. **Outpatient occupational therapy** – (precertification required beyond 20 sessions per condition or course of treatment).
4. **Speech therapy** – services of a speech therapist:

The services of the therapist 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 speech defect.

Speech therapist services will be covered if all the above requirements are met and:

- (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). Restorative speech therapy services are subject to utilization review when such services extend beyond a thirty-day period of treatment; or
  - (b) The services of a speech therapist are required due to a developmental delay such as autism. All speech therapy services for developmental delays are subject to utilization review.
5. **Infertility**—diagnosis and therapy to determine the cause of infertility, and the surgical or hormonal treatment to correct the physical problem. However, treatment to directly help you conceive or become pregnant (such as in-vitro fertilization or artificial insemination) is not covered.
  6. **Acute rehabilitation** (inpatient)—precertification required.
  7. **Cardiac rehabilitation**—precertification required for Phase III.
  8. **Penile Implants** are covered when medically necessary and are subject to pre-approval by Blue Shield.
  9. **Vasectomies** are covered.

## 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, anesthesia, 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; and
9. authorized by Blue Shield if the purchase price exceeds \$2,000.

### **Medical Supplies and Services**

Except as noted below, the following items are paid at 80% of the contract rate (if PPO), or of Usual, Customary and Reasonable charges (if non-PPO) as defined by the Plan. Non-PPO charges will *not* count toward the out-of-pocket maximum.

1. **Ambulance services**—professional ambulance transportation required to the nearest hospital equipped to provide the necessary services. 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.
2. **Artificial limbs and artificial eyes**—including their fitting, to replace any natural limbs and eyes you lose while covered under the Plan.
3. **Blood**—charges for blood, blood plasma and non-replaced blood, including their administration. Autologous blood is covered up to a maximum of four units for a covered surgery where blood loss or the need for blood is anticipated. The maximum number of units is waived if the blood is used by the donor.
4. **Immunizations**—are covered, unless the immunization is only required for you to travel outside the United States. This benefit will be paid at 100% if the immunization is a covered preventive service and a PPO provider is utilized.
5. **Injectables**—Medically necessary antigens and other therapeutic drugs administered by injection by a physician. This benefit will be paid at 60% of UCR if a non-PPO provider is utilized.
6. **Medical supplies**—such as casts, splints, and dressings.
7. **Diabetes Management**—Coverage for one educational/nutrition course of treatment for diagnosis of diabetes, paid at 80% of UCR up to \$500 per lifetime.

### **Expenses Incurred While Out of the Country:**

- a. Charges incurred during the first 90 days in any calendar year outside of the United States are paid in accordance with the Plan's benefit rules for services rendered outside of a 30-mile radius of a contract hospital (i.e., the Plan will pay 60% of UCR, but the annual \$200 non-PPO hospital deductible will not apply, and the applicable charges will count toward the out-of-pocket maximum).
- b. After the first 90 days of a temporary stay, the benefit rules of services rendered outside the geographical area of the Plan continue to apply if a participating employer has requested approval of coverage from the Board of Trustees connected to covered employment

performed outside the United States, and the Board of Trustees, in their sole discretion, has determined that such coverage will pose no undue risk to the Plan.

Both (a) and (b) above are subject to the following limitations:

- i. If the participant or dependent is entitled to Medicare, then the plan will pay no more than the benefits that it would have paid (i.e., the same percentage of the same Medicare limiting charge) had the services or supplies been rendered in the United States under a Medicare limiting charge; and
- ii. In no event shall the benefits be paid in excess of the contracted rate for similar services or supplies for Preferred Providers in the geographical area of the Plan; and
- iii. All charges in excess of Plan benefits are the responsibility of the patient, but participants and dependents will receive credit, for out-of-pocket purposes, only for the amounts for which a participant or dependent would have been credited had the services or supplies been rendered in the United States.

## Organ Transplants

Allowable Expenses incurred for a Covered Transplant Procedure during an eligible Employee's or Dependent's Transplant Benefit Period will be payable, up to 80% of the contract rate, 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; and
- 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 of the following human to human organ or tissue transplants performed during a Benefit Transplant Period:

- |                 |              |
|-----------------|--------------|
| (a) Bone Marrow | (e) Lung     |
| (b) Heart       | (f) Kidney   |
| (c) Heart/Lung  | (g) Pancreas |
| (d) Liver       | (h) Cornea   |

No other transplants are covered. Experimental procedures for those transplants listed are *not* covered.

**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.

### **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, which must be substantiated. Total payment for all transportation, lodging and meal costs

for all persons for the Covered Transplant Procedure shall not exceed \$5,000. IRS rules may treat reimbursements to companions as taxable income in some cases.

- 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 test, oxygen.
- g. Rehabilitation Therapy, including speech therapy (not for voice training or a lisp), audio therapy, visual therapy, occupational therapy, and physiotherapy.
- h. Surgical dressings and supplies.
- i. Expenses related to the organ or tissue donor. Benefits are reduced by any amounts paid or payable by that donor's own coverage. Donor charges are covered only if the Recipient is covered by the Plan.

### **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. Unrelated donor search charges.

## **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 60% of UCR charges for a non-PPO provider. The Indemnity Plan guarantees that:

- a. the length of hospital stay for newborn children and their mothers following a vaginal delivery will be at least 48 hours.
- b. the length of hospital stay 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).

## **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.

## **Colonoscopy or Sigmoidoscopy Examinations**

The Plan will cover colonoscopy or sigmoidoscopy examinations as part of colorectal cancer screening 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 60% of Usual Customary and Reasonable charges if services are performed by a non-PPO provider, up to \$3,500.

Colonoscopy and sigmoidoscopy examinations will be covered at intervals recommended by the U.S. Preventive Services Taskforce for your age and family history.

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 a surgery center or in a doctor's office. Preauthorization of the surgery center is not required for this procedure. If the test is performed by a PPO provider and qualifies as a preventive service, you will not have any out-of-pocket costs. If the test is performed in a non-PPO hospital, the costs can be much greater. Please be aware that regardless of where the test is performed, or whether the test was preauthorized by Blue Shield, if the procedure is either performed by a non-PPO provider and/or is not a preventive service, the Plan will only pay up to \$3,500 for the test. Be certain

that you and your physician know the extent of your coverage before you have the procedure performed.

## What The Medical Plan Does Not Cover

Although the Plan covers most types of medical services and supplies, it does not cover everything.

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

1. Charges which are not eligible expenses. Refer to page 13 for a description of eligible expenses. 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.
2. Charges determined, by the Plan or Blue Shield, to be for services or supplies that could have been provided in a more-cost effective manner without affecting the person's health.
3. Penalties for failure to call Blue Shield and follow its recommendations, as described on page 15.
4. Charges which are covered by Workers' Compensation laws or similar laws or which result from an employment-related accident or illness, except follow-up health examinations for an asbestosis-related illness as described on page 87.
5. Charges related to an injury or sickness for which you or your family member is not under the care of a doctor or provider.
6. Charges for any injury you receive while committing or attempting to commit a felony or any illegal activity, or as a result of such action.
7. Services or supplies provided to you or a covered family member for a military service-connected disability which is covered under any governmental plan or law or provided by any non-military-connected hospital or institution which does not require you to pay for the expenses in the absence of insurance.
8. Services or supplies which are provided by a hospital or institution for active military personnel or a Veteran's Administration hospital, except if:
  - a. you are a veteran receiving care for a non-military service-connected disability.
  - b. you are a retired veteran or the family member of an active or retired veteran receiving inpatient hospital care for a non-military service connected disability.
9. Charges for injury or illness resulting from an injury suffered as a result of war or any act of war or armed aggression incurred during active duty or training in the National Guard or the reserves of any state or country.
10. 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 other than deductibles by the covered person, such as services provided through an HMO.
11. Charges for services or supplies paid for by any local, state (except Medi-Cal) or federal government agency, including Medicare.
12. Charges for hospital stays, services and supplies you receive before you become covered by the Plan or after your coverage ends.

13. Charges for which a third party may be liable or legally responsible. Refer to page 85 for details.
14. Services performed by a person who lives in your home or is related to you by blood or marriage.
15. Dental work or dental surgery, except as an inpatient in a hospital or outpatient in an ambulatory surgical center with documentation of a concurrent medical condition, both subject to pre-certification. Refer to page 46 for other dental benefits.
16. Drug or alcohol addiction expenses, except detoxification. See page 49 for your drug and alcohol treatment benefits under the Recovery Program.
17. Pre-marital examinations.
18. Cosmetic surgery or procedures.
19. Experimental treatment or procedures. Includes charges for medical equipment, supplies, prescribed drugs, procedures or treatments which are experimental or investigative in nature and have not been established as safe or effective, or are not in accordance with generally accepted professional standards to treat a specifically diagnosed illness or injury. The determination, which will be made without regard to "medical necessity," will be subject to Plan appeal procedures. To determine whether a particular accommodation, service, supply, or other item meets the definition of "experimental treatment," the Trust may review established utilization review procedures and refer to current applicable literature, including AMA guidelines, and federal and state laws and regulations.
20. Services ordered by a court to be obtained by a Participant or dependent.
21. Investigative treatment (see "experimental treatment or procedures", above).
22. Eye Surgery or other procedures to correct refractive errors, such as Lasik surgery. See page 51 for your vision care benefits.
23. Outpatient prescription drugs. See page 38 for your prescription drug benefits.
24. Reversal or attempted reversal of an elective sterilization procedure.
25. Elective abortions.
26. Charges related to the pregnancy of your child. The Plan does not cover maternity expenses for your pregnant child (other than covered preventive services described on page 24).
27. Treatment for Temporomandibular Joint (TMJ), 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.

28. Treatment for paronychia (except infectious paronychia) and routine foot care. Excision of corns or calluses or any manipulative procedure on the foot, except for closed reductions of fractures or dislocations.
29. Examinations or check-ups not related to the symptoms of an illness or injury, except as otherwise provided on page 23.
30. Custodial care or rest cures.
31. Sex change surgery and any related medical complications.
32. Therapy, supplies or counseling for sexual dysfunctions or inadequacies. Penile implants are covered subject to approval by Blue Shield.
33. Treatment to help you become pregnant, such as artificial insemination, in-vitro fertilization, embryo transfer procedures or complications associated with such procedures.
34. Air purifiers, air conditioners, humidifiers, exercise equipment and supplies for comfort, hygiene or beautification.
35. Educational services, telephone consultations and transportation, except ambulance.
36. Nutritional counseling and food supplements.
37. Rental or purchase of ramps, elevators, stair lifts, pools, spas, hot tubs and filtering systems, saunas and car hand controls.
38. Modifications made to your home, property or vehicles, regardless of their therapeutic or ease of access value.
39. Treatment, services or programs for weight reduction, diet control or obesity, including gastric bypass surgery. Also excluded are health club memberships, physical fitness programs, and nutritional counseling and food supplements, with the exception of educational/nutrition course of treatment for diagnosis of diabetes, as stated on page 28, item 7.
40. Therapeutic devices or appliances, including support garments and other non-medical items or appliances, regardless of their intended use.
41. Immunizations required solely for travel outside the United States.
42. 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.

## **Kaiser Permanente** **Health Maintenance Organization (HMO) Option**

If you live in Northern California, you may have the option to enroll yourself and your eligible family members in the Kaiser Permanente Health Plan, Inc. HMO option. Kaiser is available in many locations and offers most services through its physicians and medical facilities. When you choose the Kaiser HMO option, you will receive hospital, medical, prescription drug and surgical benefits from Kaiser instead of through this Plan, except the alcohol and drug abuse benefits described on page 49.

If you choose Kaiser, your prescription drug benefits will also be provided by Kaiser.

Your Kaiser Permanente Health Plan, Inc. HMO benefits are not described in detail herein. For details on your Kaiser benefit coverage, please refer to the Kaiser Permanente Health Plan, Inc. *Evidence of Coverage*. The *Evidence of Coverage* is the binding document between Kaiser and its members.

A Kaiser 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 physician. You must receive the services and supplies at a 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 the Kaiser *Evidence of Coverage* (EOC).

### **How To Change Medical Plan Options**

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 any time during the year, as long as you have not changed plans in the last consecutive 12 months. The only exception will be if you move out of the Kaiser service area (in which case you must enroll in the Indemnity Medical Plan). If you become eligible for Medicare and you are covered under Kaiser, you must enroll in the Kaiser Permanente Senior Advantage Plan. Any change in plan 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. 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.

Note that you must live or work within the Kaiser service area to be enrolled in Kaiser and that Kaiser requires mandatory arbitration for enrollees.

The Trustees reserve the right to require contributions from Kaiser participants for their own coverage and for their family's coverage. Kaiser offers different plans to participants on Medicare. Details on the different plans will be mailed upon request from the Trust Fund Office. Contact the Trust Fund Office for more information on the Kaiser HMO option.



## Prescription Drug Benefits...

*to help you pay the cost of necessary drugs  
prescribed by a doctor.*

## Prescription Drug Benefits

### **Who Is Covered Under the Plan**

Prescription drug benefits are provided under the Envision Rx Options, Inc. prescription drug program, for all eligible indemnity plan participants in Schedules 1, and 1A. Schedule 7 retirees are not eligible for prescription drug benefits.

*Participants enrolled in Kaiser receive their prescription drug coverage through Kaiser.*

*Deductibles and Out-of-Pocket Limits*—The amounts you pay toward your prescription drugs do not contribute to your medical deductible. However, the amounts you pay toward your prescription drugs *are counted* toward your maximum out-of-pocket limit unless you (1) use a non-network pharmacy, in which case any amount you pay in excess of what you would have paid a network pharmacy *will not be counted* toward the maximum out-of-pocket limit or (2) choose a brand name or Non-preferred prescription drug when a generic or Preferred Drug alternative was available and medically appropriate, in which case, the difference between the cost of the brand name drug and the cost of the generic or preferred drug *will not be counted* toward the maximum out-of-pocket limit. Whether a generic or preferred alternative is medically appropriate will be determined by the Plan, upon consideration of your doctor’s recommendation.

**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 Northern California Sheet Metal Workers 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.

### **How the Plan Works — and What the Plan Pays**

There are three ways you can obtain your prescription drugs under the Envision Rx program:

1. Envision Retail Network Pharmacy
2. Non-Network Pharmacy
3. Envision Mail Order Program (provided by Costco Pharmacy Mail Services)

Pharmacy prescriptions are limited to a 30-day supply, regardless of where you obtain it. If you need long-term maintenance medication and have it filled through the Mail Order Program, your doctor can write a prescription for up to a 12-month-supply; however, no more than a 90-day supply will be mailed at one time. You can order 90-day refills, if prescribed by your doctor, as you need them. You may also have maintenance medication filled at a pharmacy, for up to a 30-day supply.

The following chart shows the Prescription Drug Plan benefits:

	<b>Envision Retail Network Pharmacy</b>	<b>Non-Network Pharmacy</b>	<b>Mail Order Program (through Costco)</b>
<b>You Pay</b>	<ul style="list-style-type: none"> <li>• Generic: 25% Copay, \$5 min, \$50 max</li> <li>• Brand - Preferred: 25% Copay, \$5 min, \$100 max, \$200 Specialty Rx max</li> <li>• Brand – Non Preferred: 25% Copay, \$5 min</li> <li>• Brand – If Generic is Available: Brand copay + Cost Difference*</li> <li>• The copay applies to each prescription filled, up to a maximum supply of 30 days</li> </ul>	<p>You pay the same copayments as a Network Pharmacy</p> <p style="text-align: center;"><b>Plus</b></p> <p>The difference between the amount Envision negotiated for the same drug at a Network Pharmacy and the actual price you paid</p>	<ul style="list-style-type: none"> <li>• Generic: 25% Copay, \$5 min, \$50 max</li> <li>• Brand - Preferred: 25% Copay, \$5 min, \$100 max, \$200 Specialty Rx max</li> <li>• Brand – Non Preferred: 25% Copay, \$5 min</li> <li>• Brand – If Generic is Available: Brand copay + Cost Difference*</li> <li>• The copay applies to each prescription filled, up to a maximum supply of 30 days</li> </ul>
<b>Claim Forms</b>	You do not have to file claim forms	You must file a Direct Member Reimbursement Form	With each new prescription, you need to submit a Mail Order Form. You can phone in requests for refills, or order drugs online from Costco.com

*\*Cost Difference is the difference between the cost of the Brand name drug and the Generic drug*

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

When you use an Envision Retail Network Pharmacy, you pay a copayment of 25% of the cost of the prescription drug, whether the drug is generic or brand name. There is a \$5 minimum and a \$50 maximum copayment, per prescription for generic drugs. There is a \$5 minimum and a \$100 maximum copayment (\$200 maximum copayment for Specialty Rx), per prescription for brand-preferred drugs. There is a \$5 minimum and no maximum copayment for brand-non preferred drugs. For brand name drugs that have a generic option, the cost will be the brand copay plus the additional cost difference. 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 Northern California Sheet Metal Workers Prescription Drug Program ID Card to the pharmacist each time you purchase prescriptions at an Envision 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 (866) 787-0162.

Most of the major chain retail pharmacies in California participate in the Envision Retail Network Pharmacies. Additional participating pharmacy information may be obtained by

visiting the Envision Rx website at [www.envisionrx.com](http://www.envisionrx.com) and clicking on 'Find a Pharmacy' or by calling the Envision Help Desk at (800) 361-4542. If the pharmacist dispensing your prescription(s) requires assistance in submitting your claim to Envision, they may also call the Help Desk. 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.

2. **Non-Network Pharmacy** — When you use a pharmacy that does not participate in the Envision Network, you pay the full price and then submit a claim to Envision. You will need your original receipt and the Direct Member Reimbursement (DMR) Form (forms are available from Envision and the Trust Fund Office). The Plan pays up to the amount Envision would have paid for the same drug at an Envision Retail Network Pharmacy, less the applicable copayment amount.
3. **Envision Mail Order Program** — 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).

Your mail order prescription services are provided to you by Costco Pharmacy Mail Services, as part of the Costco Pharmacy Benefit Partnership. It is important to note that you need not be a member of Costco to take advantage of this service.

#### **Costco.com**

If you have access to the Internet, you can order your drugs online from Costco.com. Simply go to Costco.com and click on 'pharmacy' from the list of departments and follow the directions provided.

#### **Costco Warehouse Pharmacies**

As is the case with mail order, a Costco membership is not needed to use any retail pharmacy located within a Costco warehouse. Simply tell the entrance attendant that you are going to use the pharmacy, and you will be permitted access.

*If you are a new patient or want to order a new prescription*, you must complete the Patient Profile Form (available from Envision or the Trust Fund Office), or online at Costco.com. Insert the written prescriptions, then write your return address on the front of the self-addressed envelope (provided with the Patient Profile Form). No postage is necessary. If you have any questions, visit Costco.com and click on 'Pharmacy', or call Costco at (800) 607-6861.

**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. Visit Costco on the Internet. Go to Costco.com, click on 'Pharmacy', then on 'Fill Prescriptions' to place your order. Ordering online allows you to get e-mail refill reminders. Use 'Quickfill' to reorder quickly and check out in one visit. Your prescription(s) will arrive in 6 to 11 business days.
2. Refill your prescription(s) by telephone. Simply call (800) 607-6861. Your prescription(s) will arrive in 6 to 11 business days.
3. Mail in your refill request by completing the Patient Profile Form (available from Envision or the Trust Fund Office). Your prescription(s) will arrive in 9 to 14 business days.

*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 Costco Mail Order Program 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.

## **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. Many times these medications are not available at your local drug store. Envision Rx Options offers a specialty drug program provider, Costco Specialty Pharmacy, to provide these medications. These medications are shipped directly to your house or location of choice and Costco Specialty Pharmacy will call you when it is time for a refill.

*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 Costco Specialty Pharmacy.*

To place your first order with Costco Specialty Pharmacy, simply give them a call at (866) 443-0060. A Costco Specialty Customer Service specialist is available Mon-Fri 7am – 7pm CST, and Saturday from 9am – 1pm CST. A representative will ask you for your insurance, physician information, and delivery instructions. **Please identify yourself as a Northern California Sheet Metal Workers' Health Care Plan member with Envision Rx Options, Inc. when calling Costco Pharmacy.** Then they will contact your doctor to verify your prescription, ensuring that you will receive your next prescription exactly when you need to.

## **Preferred (Formulary) Drugs**

Certain brand name prescription drugs are included in the Envision Preferred Drug List. 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.

For a complete and up-to-date listing of the medications on Envision's Preferred Drug List, you can visit Envision's website at [www.envisionrx.com](http://www.envisionrx.com), and click on 'Preferred Drug Listing'.

Some medications on the Preferred Drug List may not be covered under your Benefit Schedule. However, it is recommended that you utilize the prescriptions on the Preferred Drug List 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. Please remember that your copay will remain at 25% of the cost of the prescription, regardless of which prescription drug you purchase. For preferred brand drugs, there is a \$5 minimum and \$100 maximum copayment (\$200 maximum for Specialty Rx).

## **Prior Authorization and Quantity Limits**

The Prescription Drug Program requires prior authorization and quantity limits on certain drugs. For example, a prescription for Singulair will only be filled for a diagnosis of asthma, and adults must have failed non-sedating antihistamines. When a member goes to the pharmacy with a prescription for a drug that requires prior authorization, the prescription is rejected, and the member is alerted that he is to call the Envision Help Desk for prior authorization. During that call, the Envision Help Desk will obtain from the member the name and number of the prescribing physician, and the name of the drug. Envision will then fax a

form to the doctor who must sign the form and return it to Envision. The prior authorization is then good for one year. Please call the Envision Help Desk at (800) 361-4542 to see if your prescription requires prior authorization, and what steps can be taken prior to going to the pharmacy. *You will find that most drugs will not require prior authorization.* The list of drugs that currently do require prior authorization include: Singulair, Aldara, Amevive, Celebrex, Enbrel, Forteo, Growth Hormones, Humira, Infergen, Intron-A, Kineret, Neupogen, PegaSys, Pulmozyme, Procrit, Rebetrone, Rebif, Remicade, Tazorac, Testosterone, Thalomid, Vfend, Vytorin, Xopenex, and Xolair.

### **Diabetic Glucometer**

If you or your eligible dependent is diabetic, Envision Rx Options has a program available to members at no charge that allows them to receive a FreeStyle Glucometer, at no cost, to replace an existing glucometer. Simply call (866) 224-8892 and identify yourself as an Envision Rx Options member, and FreeStyle will take care of the rest. The FreeStyle Glucometer utilizes state-of-the-art technology and requires the smallest blood sample of any glucometer on the market. In addition, diabetics may use their forearms, upper arms, thighs and stomach area as additional testing sites. There is a limit to one glucometer per member.

### **Expenses Covered by the Plan**

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

- Medically necessary,
- Prescribed by a licensed doctor,
- Can be obtained only with a prescription from a licensed doctor (except for diabetic and ostomy supplies),
- Amounts within Envision's usual, customary, and reasonable limits, and
- Covered by the Plan.

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 Envision at (800) 361-4542.

## Prescription Drug Expenses Not Covered by the Plan

The Plan does not cover the following:

1. Prescription drug expenses that are not medically necessary, prescribed by a doctor, within the reasonable and customary limits, or are not 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 drugs or items covered as a preventive service, insulin, diabetic supplies, syringes, and ostomy bags and devices).
4. Charges for cosmetics, health and beauty aids, contraceptives (except preventive services—see page 24), immunization agents (except preventive services), appliances, and non-drug items.
5. Charges for Prescription Drugs used primarily for cosmetic purposes, including but not limited to Rogaine.
6. Experimental or investigative drugs.
7. An unreasonable supply of drugs as determined by Envision.
8. Charges for injury or illness resulting from an injury suffered as a result of war or any act of war or armed aggression incurred during active duty or training in the National Guard or the reserves of any state or country.
9. Expenses which are covered by Workers' Compensation laws or similar laws or which result from an employment-related accident or illness.
10. Drugs paid for by any local, state (except Medi-Cal) or federal government agency, including Medicare.
11. Expenses related to a military service-connected disability.
12. Drugs provided by a hospital or institution for active military personnel or a Veteran's Administration hospital, except if you are a veteran receiving care for a non-military service-connected disability.
13. Expenses that you would not legally have to pay (or would not be charged for) if you had no health care coverage.
14. Drugs needed for an injury you receive while committing or attempting to commit a felony or any illegal activity, or as a result of such action.
15. Off-Label Drugs

Medications are only covered for FDA approved or labeled indications. Off-label indications are not covered.

A drug that has FDA approval but is being used for an indication or at a dosage that is not an accepted "off-label" use will not be considered experimental if that drug has been prescribed for the treatment of a life-threatening or chronic and seriously debilitating condition and the drug has been recognized for treatment of that condition by one of the following:

- The American Medical Association Drug Evaluations,
- The American Hospital Formulary Service Drug Information,
- The United States Pharmacopoeia Dispensing Information, Volume 1, "Drug Information for the Health Care Professional," or

- Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective, unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

If requested by the Plan, a provider who prescribes the drug will be responsible for submission of documentation supporting compliance with these requirements.

A “life-threatening condition” means either or both of the following: a disease or condition in which the likelihood of death is high unless the course of the disease is interrupted or a disease or condition that has potential fatal outcome, where the end point of clinical intervention is survival.

A “chronic and seriously debilitating condition” means diseases or conditions that require ongoing treatment to maintain remission or prevent deterioration and cause long-term morbidity.

### **Where to Find More Information**

Call Envision’s Help Desk at (800) 361-4542:

- To find out what pharmacies participate in the Envision Network (near your home or if you are traveling)
- To request DMR forms and mail order prescription drug forms
- To find out which drugs on Envision’s preferred drug list are covered by the Plan
- To request that a pharmacy be added to the Envision Retail Network

Additional DMR forms and mail order forms are also available from the Trust Fund Office.



## Dental Benefits

*to help pay the cost of necessary dental expenses  
for you and your family.*

## **Dental Benefits**

Dental benefits are available to you and your eligible family members through Delta Dental if you are covered under Schedule 1 or 1A. Schedule 7 retirees are not eligible for dental benefits.

The Plan pays a percentage of your eligible dental expenses, but not more than the amount you are charged. Eligible dental expenses must be necessary for your dental care, prescribed by a dentist or dental surgeon, within reasonable and customary limits and covered by the Plan.

### **Annual Dental Maximum**

**Active and Retired Participants and Their Covered Family Members**—Covered dental benefits (excluding orthodontia) are limited to \$2,000 per covered individual, every calendar year. There is no calendar year maximum for pediatric dental benefits (under age 18).

### **Preventive Services**

The Plan pays 100% for covered preventive services up to reasonable and customary charges. Preventive services include:

- Oral examinations (2 per calendar year).
- X-rays (Bitewings are limited to 2 sets per calendar year. Full mouth series are limited to once every 36 months).
- Teeth cleaning. (2 per calendar year).
- Fluoride application for children under age 18 (2 per calendar year).
- Sealants for dependent children until age 14.

### **Other Services**

The Plan pays 80% for other covered dental services up to reasonable and customary charges. Other covered services include:

- Space maintainers.
- Fillings and other restorative services.
- Crowns, bridges and other prosthodontia services (once in a 3-year period).
- Extractions and other types of oral surgery.
- Root canal therapy and other types of endodontic treatment.
- Treatment of periodontal diseases and other diseases of the gums and tissues of the mouth.
- Full and partial dentures and their repair.

### **Orthodontia Benefits for Schedule 1 and 1A**

The Plan pays 50% of your eligible orthodontia expenses, after you pay a separate \$50 orthodontia deductible each calendar year. The maximum lifetime benefit for orthodontics is \$2,000 per person.

*Refer to the Delta Dental Evidence of Coverage booklet for more information*

## **Bright Now! / Newport Dental**

You may have the option to enroll yourself and your eligible family members in the Bright Now!/Newport Dental option. When you choose the Bright Now!/Newport Dental option, you will receive dental and orthodontic benefits from Bright Now!/Newport Dental instead of with the Delta Dental Plan.

Bright Now!/Newport Dental is a pre-paid dental plan similar to an HMO. You and your eligible dependents will be covered under the Bright Now!/Newport 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. There is no deductible or yearly maximum, and no charge for basic and preventive care (such as cleanings), fillings and root canals. Call the Trust Fund Office at (866) 787-0162 or Bright Now!/Newport Dental at (800) 497-6453 for more information.

Orthodontic services are provided as part of the dental benefits provided by Bright Now!/Newport Dental, subject to the following provisions:

- There is a one-time diagnostic work-up and x-ray surcharge of **\$540.00** for a full-banded two-year case and **\$460.00** for one set of retainers.
- Orthodontic treatment must be provided by a member of the orthodontic panel who is providing said treatment under a contract with Bright Now!/Newport Dental.



## The Recovery Program

*to provide confidential help when you or your covered family members have a drug or alcohol abuse problem.*

## **Alcohol And Drug Abuse Treatment Benefits**

The Recovery Program helps you and your family if you have alcohol or drug abuse problems. This program is available to Participants in all Benefit Schedules.

The Recovery Program provides benefits for detoxification, rehabilitative treatment, approved family counseling and face-to-face follow-up for one year after treatment. All counseling and treatment is confidential—the Trust Fund Office and TARP (the program administrator) must keep all information confidential.

Call TARP Monday through Friday from 8:00 am to 5:00 pm at: (800) 522-TARP (8277).

A program advisor will arrange a face-to-face meeting to determine an individual treatment program.

### **Recovery Program Benefits**

#### **Inpatient Treatment**

The program pays the following benefits that have been pre-approved (precertified) by TARP:

- 90% of covered expenses for the first course of treatment from PPO providers
- 80% of covered expenses for each subsequent course of treatment thereafter from PPO providers
- 60% of UCR charges for non-PPO providers.

#### **Outpatient Treatment**

The program pays the following benefits:

- 80% of covered expense for each course of treatment from PPO providers.
- 60% of UCR charges for non-PPO providers.

A course of treatment is a period of time that begins on the day a covered individual:

- enrolls in an outpatient program
- is admitted for inpatient treatment approved by TARP or
- enrolls in a combination of an outpatient and an inpatient program.

A course of treatment ends on the day a covered individual:

- completes the program, including prescribed after-care, or
- elects to leave the program before its completion.

### **If You Become Disabled Due to Alcoholism or Drug Abuse**

In addition to meeting all the requirements to be considered a disabled employee under the Plan as described on page 67, if you become disabled due to alcoholism or drug abuse, to qualify for disability coverage under the Plan, you must enroll for a course of treatment in either an outpatient or inpatient facility coordinated by the Recovery Program. You will be required to submit proof to the Trust Fund Office that you have enrolled in a course of treatment.



## Vision Benefits

*to help you pay the cost of vision care provided by a licensed optometrist or ophthalmologist.*

## Vision Benefits

Vision benefits are available to you and your eligible family members through Vision Service Plan (VSP) if you are eligible for Benefit Schedule 1 or 1A. Schedule 7 retirees are not eligible for vision benefits. Call the Trust Fund Office at (866) 787-0162 or VSP at (800) 877-7195 or visit [vsp.com](http://vsp.com) for more information.

VSP benefits are only available from the doctors listed in the VSP provider directory.

### **Summary of Vision Care Benefits:**

Copayment \$10 Exam, \$25 Materials

### Schedule of Benefits (VSP Provider)

Exam	Covered up to VSP allowances every 12 months
Lenses	Covered up to VSP allowances every 24 months
Frames	Covered up to VSP allowances every 24 months
Contact Lenses (necessary)	Exam and materials covered every 24 months
Contact Lenses (elective)	Covered up to \$130 every 24 months; in lieu of lenses and frames

### Schedule of Benefits (Non-VSP Provider)

Exam	Up to \$50
Lenses:	
Single Vision	Up to \$50
Bifocal	Up to \$75
Trifocal	Up to \$100
Lenticular	Up to \$125
Frames	Up to \$70
Contact Lenses (necessary)	Up to \$210
Contact Lenses (elective)	Up to \$105



# Health Reimbursement Arrangement

*to help you pay for qualifying medical and dental expenses*

## Health Reimbursement Arrangement

The Health Reimbursement Arrangement (HRA) 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-benefits.

### **Eligibility for Contributions**

- Your HRA Individual Account will initially be credited a minimum of \$0.25 for each hour of covered employment on or after January 1, 2011. Subject to Trust policy, your bargaining unit may agree to pay for additional credits effective on or after July 1, 2011. You can draw on your HRA Individual Account to pay health care costs that you are responsible for, such as co-payments, charges that exceed what the Plan will pay, and self-pay benefits. Any amounts that you do not use during the current calendar year will be carried over from year to year. You can continue to use your HRA Individual Account after you retire. Your HRA Individual Account credit is not counted as part of your Hour Bank for any purpose.
- If you are covered under a subscription agreement, and your employer pays a monthly flat rate on your behalf, your HRA Individual Account will be credited as though you worked 142 hours in the month. For example, if your credit rate is \$0.25 per hour, you will be credited with \$35.50 per month.
- If you are a member of another union working in Local 104, District 2's jurisdiction, you are not eligible for an HRA Individual Account. If you are a Local 104, District 2 member working in another jurisdiction under a reciprocity agreement at a health and welfare rate **lower** than the Local 104, District 2 rate, you will not receive an HRA credit. Instead, your reciprocal contribution will be applied to "buy" hours under the Plan to permit the maximum allocation for current health and welfare eligibility. For example, assume that your unit receives a \$2.00 per hour HRA credit, and the Plan contribution rate is \$10.63 per hour. If the reciprocal contribution is 100 hours @ \$8.00 per hour, for a total reciprocal contribution of \$800.00 reciprocal contribution would "buy" 75.26 hours toward your Plan coverage, with no HRA credit. If you are a Local 104, District 2 member working in another jurisdiction under a reciprocity agreement at a health and welfare rate **higher** than the Local 104, District 2 rate, you will receive an HRA credit. Your hours will be credited on a *pro rata* basis depending on how many hours the reciprocal contribution would "buy" under the Plan with an allocation to the HRA fund. For example, if the reciprocal contribution is 100 hours @ \$12.00 per hour, for a total reciprocal contribution of \$1,200.00, the \$1,200 reciprocal contribution would "buy" 95.01 hours toward your Plan coverage and an HRA credit of \$190.02 (95.01 x \$2.00).
- Note that you will not receive an HRA credit in this Plan while you are working under a contract between Local 104, District 1 and a signatory employer or association.

### **Reimbursement of Qualified Expenses**

- In order to qualify for reimbursement, an expense must satisfy all of the following requirements:
  1. The expense must be for a health care expense that is deductible for federal income tax purposes (Internal Revenue Code 213(d)), including out-of-pocket costs you incur under your Plan. Qualified expenses include:
    - Plan co-payments, deductibles and coinsurance;

- Premiums for health and dental insurance coverage offered through the Plan, including self-payment, COBRA payment to continue coverage once your Hour Bank is exhausted and retiree coverage; and
  - Other medical expenses not covered by the Plan, but deductible for federal income tax purposes (e.g., Lasik surgery, orthodontics, etc.)
2. The expense must have been incurred by you or your eligible dependent(s) covered by the Plan
  3. The expense must be incurred on or after July 1, 2011.
  4. You or your eligible dependent(s) must provide proof, satisfactory to the Board of Trustees, that the claim satisfies the requirements of this section.

### **Procedures for Payment of Reimbursement from HRA Account benefits**

1. Benefits will be paid only to you or your 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 Arrangement Account benefits is not allowed.
2. You can use your Benny Card like a MasterCard to pay for qualifying expenses at a provider's office or pharmacy. Additional credits will be added to your Benny Card as you continue to work in covered employment and you can check how much your credit is online.
3. Claims for reimbursement may be submitted within 12 months from the date of service on a form approved by the Trustees. Payment of claims will be subject to the Plan's regular claims payment procedures. If you or your eligible dependent's claim is denied, you may appeal that denial to the Board of Trustees, under the Plan's general appeal procedures.

### **Termination of Covered Employment**

- If you terminate your covered employment, you may continue to submit claims for reimbursement until your HRA Individual Account is exhausted. You may instead choose to leave your HRA Individual Account intact to pay for future Qualified Expenses, including retiree coverage.

### **Disposition Upon your Death or Termination of HRA Program**

- If you die with any credits remaining in your HRA Individual Account and other coverage is exhausted, your surviving eligible dependents may use the credits to elect COBRA continuation coverage or pay for other qualified expenses. If your HRA Individual Account credits fall below the monthly COBRA premium, 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 your coverage, your HRA Individual Account shall be forfeited back to the Plan.
- *The HRA is funded only by employer contributions pursuant to collective bargaining agreements, and is not a vested benefit.* You cannot elect to make payments to your HRA Individual Account. There is no individual right to assets in the HRA and credits in your HRA Individual Account cannot be converted to cash or rolled over. This program may be terminated by the Board of Trustees at any time, in which event all credit balances in HRA Individual Accounts shall revert to the general assets of the Plan.

## **Opt-out From HRA Program**

- You can opt out of the HRA at any time. If you elect to opt-out of the HRA, you will not be able to use any of the credits you have accumulated in your HRA Individual Account and will not receive any additional credits in the future. Your election to opt out of the HRA is permanent and may not be revoked, even if you return to covered employment. You may want to opt out of the HRA because employees with HRA balances are not eligible for premium tax credits (subsidies) when purchasing individual coverage on the health care marketplace (“Covered California”). In certain cases, it may be in your advantage to opt out of the HRA to receive premium tax credits if you are considering marketplace coverage. Because opt out is permanent, you should weigh this decision very carefully. Contact the Trust Fund Office if you wish to opt out of the HRA.



## Life Insurance and Accidental Death and Dismemberment Benefits...

*to provide financial assistance to your covered survivors if you die, if your covered spouse or child dies or if you or a covered family member loses a hand, foot or eye in an accident.*

## Life Insurance And Accidental Death And Dismemberment Benefits

Life insurance and accidental death and dismemberment (AD&D) benefits are available to you and your covered family members, if you are covered under Schedule 1, 1A, or 7.

If you are covered by the Plan when you die, the Plan pays life insurance benefits to your beneficiary — the person you named to receive the benefit.

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. Refer to the chart below for the benefits that apply to you.

<b>Employment Status</b>	<b>Death Benefit Sch 1</b>	<b>Death Benefit Sch 1A &amp; 7</b>	<b>Accidental Death Benefit Sch 1, 1A, &amp; 7</b>
Employee	\$50,000	\$10,000	\$10,000
Unemployed employee	50,000	10,000	10,000
Disabled employee	50,000	10,000	N/A
Retired employee < age 65	10,000	10,000	10,000
Retired employee age 65 +	1,000	1,000	N/A
Disabled retiree < age 65	1,000	1,000	N/A

If your surviving spouse was covered by the Plan on the date he or she dies, life insurance benefits are available for his or her beneficiary, as follows.

<b>Status</b>	<b>Death Benefit Sch 1, 1A, &amp; 7</b>	<b>Accidental Death Benefit Sch 1, 1A, &amp; 7</b>
Surviving spouse (your widow / widower) < age 65	\$2,000	\$2,000
Surviving spouse (your widow / widower) age 65 +	\$500	N/A

Refer to page 73 for the eligibility requirements for continued Plan coverage for surviving spouses and children.

### **Dependent Life Insurance**

The Plan also provides a death benefit to you if your covered spouse or child dies. 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. The following chart applies to Schedules 1, 1A, and 7.

Dependent Status	Death Benefit	Accidental Death Benefit
Your covered dependents, if you are an employee, unemployed employee or a retiree under age 65 <ul style="list-style-type: none"> <li>• dependents 6 months of age or &gt;</li> <li>• dependents under 6 months of age</li> </ul>	\$8,000  2,000	\$4,000  2,000
Your covered dependents, if you are a disabled employee or retiree or a retiree age 65 or over <ul style="list-style-type: none"> <li>• dependents 6 months of age or &gt;</li> <li>• dependents under 6 months of age</li> </ul>	\$500  100	Not applicable  Not applicable
Covered dependents of your surviving spouse (your widow or widower) who is age 65 or over <ul style="list-style-type: none"> <li>• dependents 6 months of age or &gt;</li> <li>• dependents under 6 months of age</li> </ul>	\$100  100	Not applicable  Not applicable
Covered dependents of your surviving spouse (your widow or widower) who is under age 65 <ul style="list-style-type: none"> <li>• dependents 6 months of age or &gt;</li> <li>• dependents under 6 months of age</li> </ul>	\$500  100	\$500  100

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

- dies while committing or attempting to commit a felony or other illegal activity, or as a result of such action, or
- dies as a result of war, whether declared or undeclared, or insurrection.

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

**Dismemberment Benefits (for Schedules 1, 1A, and 7)**

You and your covered family members 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 family members is \$3,000 payable for the loss of one or more hands, feet or sight of an eye resulting from one accident.

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.

Losses due to war, intentional self-inflicted injuries or involvement in any illegal activity are not covered.

### **Designating Your Beneficiary**

You can choose anyone, including your estate, to be the beneficiary of your death benefit. You must designate your beneficiary on an Enrollment/Beneficiary Card that must be filed at the Trust Fund Office. It is your responsibility to ensure that the Enrollment/Beneficiary Card reflects current information.

If you are married and designate someone other than your spouse as your beneficiary, your spouse must give consent in writing. If your spouse does not give written consent, he or she will receive one-half of your death benefit and your designated beneficiary will receive the other half. If you and your spouse divorce or legally separate, the designation of such spouse as the beneficiary will automatically be revoked, unless a court judgment or order provides otherwise.

If you do not file a beneficiary designation with the Trust Fund Office or if your designated beneficiary is not living, the Plan pays benefits to the first of the following: (1) your spouse, (2) your children, including your legally adopted children, (3) your siblings (in equal shares), and (4) the executors or administrators of your estate.

If your spouse dies, the Plan pays benefits to you. However, if you are not living when your spouse dies, the Plan pays benefits to the first of the following: (1) your spouse's surviving descendants by right of representation (2) your spouse's surviving siblings (in equal shares), or (3) the executors or administrators of your spouse's estate.

If your child dies, the Plan pays benefits to you. If you are not living when your child dies, the Plan pays benefits to the first of the following: (1) your child's children, (2) your child's parents (in equal shares), (3) your child's surviving siblings (in equal shares), or (4) the executors or administrators of your child's estate.

If there are no surviving beneficiaries in any of these classes, no death benefit will be payable, other than necessary burial expenses, not to exceed \$1,000.

Benefits which the Plan pays to a minor may be paid to his or her legally appointed guardian. If the child has no guardian, then the Plan pays benefits to the adult or adults who have complied with California's legal requirements for receipt of the benefits on behalf of the child.

You cannot assign your death benefit to someone other than your beneficiary, such as a creditor. However, when you die, your beneficiary may assign the benefit to another party if the Trust Fund Office receives the proper documentation in a timely manner.

The application for benefits must be received by the Plan within 12 months of the covered person's death or dismemberment.

Benefits are not payable to a beneficiary who was involved in the homicide of the covered person.

### **What To Do In The Event Of Death**

You or your beneficiary must submit a Certified Death Certificate to the Trust Fund Office. The Trust Fund Office will in turn send each beneficiary an application to be completed in order for the benefits to be distributed. It is your responsibility to ensure that your Enrollment/Beneficiary Card reflects current information.



## When Coverage Ends...

*generally, when you or your family members no longer meet the requirements for Plan coverage.*

## When Your Coverage Ends

Generally, coverage under the Plan ends when you or your family members no longer meet the requirements for Plan coverage. However, there may be times when continued coverage is available for a limited period of time. (See pages 64-77)

Coverage for you and your family members will end on the earliest of the following dates:

- The last day of the month in which your Reserve Hour Bank provides the minimum required hours. For example, assume you are covered under Benefit Schedule 1 and stop working in June. Also assume you have 375 hours in your Reserve Hour Bank after the deduction for your July eligibility. 360 of those hours will provide you with eligibility under Schedule 1 for August, September and October (120 hours times 3). Your eligibility will then terminate at the end of October, since the fifteen hours remaining in your Reserve Hour Bank will be less than the 120 minimum hours required to provide further eligibility.
- The date you or your family member enters full-time military service. Special provisions apply to you if you are a military reservist called to active duty. See page 68 for details.
- The date you die. However, your surviving family members may continue coverage with certain limitations, as described on page 73.
- The date you or your family member no longer satisfies the Plan's eligibility requirements. If your family member is injured when Plan coverage would otherwise end, the Plan will continue his or her coverage for up to 90 days, for expenses related to that injury. Coverage will continue through the last day of the month in which a child attains the limiting age for eligibility, as described on page 5.
- The last day of the second month following the month in which you work in non-covered sheet metal service, as described on page 79.
- The date your union membership lapses as described on page 79.
- The last day of the second month following the month in which your employee group withdraws 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 cancelled at the time the Contribution Agreement terminates. An employee group is considered to have withdrawn from the Plan under either of the following circumstances:
  5. Where contributions to this Plan on behalf of the employee group are no longer required under a collective bargaining agreement (or Subscription Agreement).
  6. 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.
- The date your COBRA continuation coverage ends, as described on pages 74-77.
- The date the Plan is terminated.

### **Certification of Coverage**

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 gives you and your covered dependents the right to receive certification of health care coverage when your participation in the Plan ends. Under HIPAA, this certification could be used to satisfy pre-existing condition limitations, if any, that may apply under other employers' health care plans. You will receive certification of coverage when:

- **Your or your dependent's active health care coverage ends** under this Plan, regardless of whether the loss of coverage is a COBRA-qualifying event; and
- **Your or your dependent's COBRA coverage ends** under this Plan.

Certifications will be mailed to the address on file with the Trust Fund Office. Separate certifications will be mailed to qualified family members who live at another address. You may want to keep your certification with your important personal documents.

Because the Affordable Care Act eliminates preexisting condition exclusions, the Plan will not send any certifications for coverage ending after December 31, 2014.

### **Marketplace Coverage (Covered California)**

There may be other coverage options for you and your family. You may wish to purchase coverage from the Health Insurance Marketplace ("Covered California"). In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. If your income is low enough, you may even qualify for coverage at no cost to you.

Being eligible for COBRA or a self-pay option does not limit your eligibility for coverage for a tax credit through the Marketplace. However, you should be aware that if you elect COBRA or a self-pay option upon losing your regular coverage, you will be ineligible for Marketplace coverage until the earlier of (1) the date you exhaust your COBRA or self-pay eligibility or (2) the next annual Marketplace open enrollment (October-December) unless you are entitled to special enrollment (e.g., you are adding a dependent).

You can find out more about your Marketplace options at the Covered California website: [www.coveredca.com](http://www.coveredca.com).



# Continuing Plan Coverage...

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

## **Continuing Plan Coverage**

When certain events occur in your life, protection under the Plan for you and your eligible family members can continue for a limited period of time, even if your Reserve Hour Bank has been exhausted.

These life events are:

- A. Unemployment or Reduction in Hours (page 66)
- B. Disability (page 67)
- C. Call To Active Military Duty (page 68)
- D. Retirement (page 68)
- E. Death (page 73)
- F. COBRA Continuation Coverage (page 74)

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 can use the remaining hours in your Reserve Hour Bank and then continue coverage by paying for it, provided you 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 pages 74-77.

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, you may be eligible to continue Plan coverage through COBRA, subsidized self-pay coverage, or a retiree plan. Your cost will depend on factors such as your employment status, your benefit schedule, your family members, 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.

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 preceding 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.

*Regardless of the reason your coverage is continued, once you stop making payments, your coverage cannot begin again until you re-establish your eligibility under the eligibility provisions of the Plan.*

### **A. If You Become Unemployed**

If you become unemployed but remain on an “Unemployed/ Available to 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 paying for it, provided you remain on an “Unemployed/ Available to Work” list, and you satisfy both of the following requirements:

1. Your employer contributed to the Plan on your behalf for at least 500 hours during the 12-month period immediately preceding your unemployment, or  
Your employer contributed to the Plan on your behalf for at least 3,000 hours during the 36-month Period immediately preceding your unemployment. This condition can be partially or fully satisfied by work you have performed for a Government Agency Employer, even though that employer did not contribute to this Plan.
2. 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 to not more than 30 days prior to the date you applied for coverage under this Plan. You must submit evidence to the Trust Fund Office that you were (and are no longer) continuously covered under your spouse’s plan.

If you meet the above requirements, but fail to remain on the “Unemployed/ Available to Work” list because you have accepted employment outside the United States, you will have the same coverage options as an unemployed person who remains on the list. Your coverage through the Plan while you remain out of the country can continue for the lesser of 90 days or the time it takes to establish eligibility through your current employment.

#### ***How Long You Can Continue Coverage...***

You can continue Plan coverage for up to 12 months from the date you no longer have enough hours in your Reserve Hour Bank if you are covered under Schedules 1 or 1A.

For example, assume you are in Schedule 1 and become unemployed in May 2004. 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 2003 and May 2004. Therefore, you can continue coverage for the 12-month period beginning July 1, 2004 and ending June 30, 2005, provided you remain on the “Unemployed/ Available for Work” list.

Special provisions may apply to you if you become unemployed prior to retirement. See above for details.

#### ***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. Refer to page 65 for the payment procedure in subsequent months.

*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. This exception will apply only so long as you are covered under your spouse’s plan. You must apply for coverage under the Northern California Sheet Metal Workers

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) continuously covered under your spouse's plan.

***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/ Available 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.

**B. If You Become Disabled**

You will be considered a disabled employee under the Plan so long as illness or injury makes you unable to engage in any employment or gainful pursuit, other than casual, for at least 14 days. For example, in no case will 100 or more hours a month be considered as "casual" employment. However, simply because you work less than 100 hours a month does not automatically mean your employment will be considered as "casual." The illness or injury must occur while your coverage is maintained by your Reserve Hour Bank, but it need not occur while you are actually on the job. If you do work hours considered "casual," you will not receive credit for which you have received payment.

If you are disabled, you will receive an additional month of eligibility for every month of your disability, up to a maximum of 12 months for Schedules 1 and 1A. This extended coverage will be at no cost to you, except for any employee contribution you would normally pay, and will satisfy your employer's obligation to provide up to three (3) months of medical coverage if you are off work due to a serious medical condition under the Family and Medical Leave Act (FMLA). For an explanation of all your rights to continued coverage under FMLA, see page 96. You will be eligible for another maximum period of no-cost disability coverage for an entirely different disabling condition, after you have returned to work long enough to establish one month of eligibility by active hours in your benefit schedule.

The maximum period for which coverage will be provided for any one disabling condition and any one period of disability is 12 months for Schedules 1 and 1A. This rule will be waived if you return to work for at least 12 consecutive months.

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 cause 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 49. You will be required to submit proof to the Trust Fund Office that you have enrolled in a course of treatment.

If you are totally or partially disabled, you may be eligible for coverage under the Plan as a retiree. See page 70 for details.

***Using Your Reserve Hour Bank...***

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

### ***After You Use Your Reserve Hour Bank You May Apply For Continued Coverage...***

If you are still disabled when the eligibility in your Reserve Hour Bank runs out, you may elect to continue Plan coverage by making subsidized self-payments. You can use this means of extending coverage for up to 12 months if you are covered under Schedules 1 or 1A, and that period will be included as part of your COBRA continuation period.

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. During that month, you must also pay for coverage that starts that month. From then on, you must continue paying by the 20th of the month for the extended coverage, as described on page 65.

When you apply for continued coverage, you must submit proof of your disability. Continued proof of your disability will be required by the Trust Fund Office, and the Plan reserves the right to have you examined by a doctor of its choice in order to be certified as disabled.

The disability benefits described above may not be available if you are covered under a Subscription Agreement with the Plan. Instead, there may be special provisions for coverage under the agreement. Call the Trust Fund Office for more information.

### **C. If You Leave Your Employment For Active Military Duty**

If you leave your employment to serve active duty in the U.S. Military, including being called to active duty from the U.S. Military Reserve, you may continue your coverage under the Plan while you serve on active duty. You may use your Reserve Hours Bank for coverage part of the time you are on active duty, plus receive a maximum of 24 months of additional coverage (35 months if you are deemed disabled by the Social Security Administration), as follows:

You must provide evidence of your active status in the military. In that case, you and your covered family members will be covered under the Plan at no cost to you during the initial time of your active military service, up to a maximum of six months. Your benefits will be provided under the schedule for which your employer was contributing when you were activated into the service.

If you are still on active duty at the end of six months, your coverage will continue through your Reserve Hour Bank. When that runs out, you may continue your coverage by paying for it. You can use this means of extending coverage for up to 18 additional months (29 months if you are eligible for a disability extension) pursuant to COBRA continuation coverage, as described on pages 74-77.

### ***Applying For Coverage While On Active Duty...***

You must elect to extend your coverage during the first month your Reserve Hour Bank runs out. During that month, you must also pay for coverage that starts that month. From then on, you must continue paying by the 20th of the month for the extended coverage, as described on page 65.

### **D. If You Retire**

**You will be considered a retired employee under the Plan if:**

1. You are age 52 or over. If you are between the ages of 52 and 55, you must be receiving a pension from the Sheet Metal Workers of Northern California Pension Plan to be considered a retired employee under this Plan,
2. You have "completely retired" from the sheet metal trade (except for certain part-time consulting work as defined in the Plan),

3. You have had eligibility under the Plan for at least 60 out of the 84 calendar months immediately preceding the month in which you retire. Any time during which you are covered under the Plan as a disabled or unemployed employee immediately before your retirement will count toward your 60 months. (However, any time during which you are on COBRA continuation coverage does not count toward your 60 months.), and
4. You maintain your membership in Local 104 (the successor to Local 162) of the Sheet Metal Workers International Association that is sponsoring the Plan.

\*If you do not have at least 60 out of 84 calendar months of active coverage at retirement, you may purchase up to three (3) additional months of eligibility to apply toward the 60-month requirement in paragraph 3 above if you meet each of the following requirements:

1. You must have been a member of Local 104 or Local 162 for at least 10 years prior to your retirement.
2. You must have been on the Local 162 out-of-work list for at least three (3) months (need not be consecutive) between January 2009 and December 2011, during which months you paid union dues and did not refuse any work.
3. For each additional month of eligibility, you pay to the Trust (or use your HRA credit) the current monthly retiree self-pay premium based on your age at retirement.

**You will be considered “completely retired” if:**

1. 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, or
2. 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 are eligible if you work less than 40 hours per month as a part-time instructor.

**Important Requirement To Report To Work** — When you perform *any* work in the sheet metal industry or at a construction site, you must notify the Trust Fund Office immediately. *Failure to notify the Trust Fund Office will make you ineligible for Plan coverage as a retiree.*

When you retire, the available coverage under the Plan will continue for you and your eligible family members for as long as there are sufficient hours in your Reserve Hour Bank to provide eligibility.

***If You Are a Non-Bargaining Unit Employee...***

If you are a non-bargaining unit employee covered under a Subscription Agreement with the Plan and are not a member of a bargaining unit, other than an Owner/Member, you will be considered a retired employee under the Plan if you meet all three of the following requirements:

1. You are age 52 or over;
2. You have “completely retired” from the sheet metal trade (except for certain part-time consulting work as defined in the Plan); and

3. You have had eligibility under the Plan for at least 60 out of the 84 calendar months immediately preceding the month in which you retire. Any time during which you are covered under the Plan as a disabled or unemployed employee immediately before your retirement will count toward your 60 months. (However, any time during which you are on COBRA continuation coverage does not count toward your 60 months.)

#### ***After You Use Your Reserve Hour Bank...***

When you no longer have sufficient hours in your Reserve Hour Bank, you can continue coverage under the Plan by paying for it, provided you meet all the above rules to be considered a retired employee.

#### ***Your Benefit Schedule...***

If you were covered under Benefit Schedule 1 or 1A while you were employed, you may choose to continue coverage under Benefit Schedule 1 or Schedule 7 when you retire.

Once you enroll in your Benefit Schedule and make your first payment, you will not be allowed to change it. In other words, if you elect Schedule 7, you cannot later change to Schedule 1.

#### ***If You Become Totally Or Partially Disabled Prior To Retirement...***

If you are totally or partially disabled (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.

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 Social Security coverage, and
2. Unable to engage in any work earning more than \$500 per month. You must report any income in excess of \$500 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 rest of your life.

The Trust Fund Office may require you to submit proof of your continuing disability from time to time. If you are under age 55 and the Trust Fund Office determines that you are no longer totally or partially disabled, your coverage will end. If you are at least age 52, coverage may continue, provided you are receiving a pension from the Sheet Metal Workers of Northern California Pension Plan. However, if you return to work on a trial basis (as allowed by Social Security) you may continue Plan coverage as a retiree.

#### ***Applying For Continued Coverage When You Retire...***

You must apply for continued coverage no later than the date you retire, although you are allowed, under limited circumstances, to delay your or your spouse's benefits to a later date.

You may elect to delay Plan coverage while you are covered under your spouse's group health plan. You must notify the Plan if you are doing so, and if you do delay your coverage in this manner, you will be allowed to commence your retiree benefits under this Plan (one time) only if you *lose* your coverage under your spouse's plan and enroll in this Plan within thirty (30) days of the loss of coverage. (You would have to lose that coverage by virtue of your spouse losing her eligibility or her plan being terminated, not because you simply decided to drop her

coverage.) Your spouse will also be permitted to enroll in this Plan at that time. You will be required to submit evidence to the Trust Fund Office that you and your spouse were (and are no longer) covered under your spouse's plan. Your rate will be based on your age at the date of your retirement, not the date your Plan coverage commences.

If you elect to continue Plan coverage upon retirement, your first payment for Plan coverage will be due during the first month in which you have insufficient hours in your Reserve Hour Bank. After you commence coverage, you may suspend your coverage one time only if you do so in order to obtain coverage through your spouse's group health plan. You must notify the Plan if you are doing so, and if you do suspend your coverage in this manner, you will be allowed to resume your retiree benefits under this Plan (one time) only if you *lose* your coverage under your spouse's plan and enroll in this Plan within thirty (30) days of the loss of coverage. (You would have to lose that coverage by virtue of your spouse losing her eligibility or her plan being terminated, not because you simply decided to drop her coverage.) Your spouse will also be permitted to enroll in this Plan at that time. 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. Your rate will be based on your age at the date of your retirement, not the date your Plan coverage recommences.

After electing retiree coverage for yourself and your spouse, you may terminate your spouse's coverage at any time on a one-time basis. *You will not be allowed to resume your spouse's coverage under the Plan in the future for any reason.* Your spouse will also not be allowed to elect COBRA coverage now or at any time in the future. Your spouse must sign a waiver form and submit it to the Trust Fund Office in order for the waiver to take effect. If you have any other dependents covered under the Plan, you may not waive your spouse's coverage. Please give careful thought to your decision to waive spousal coverage. If your spouse loses other insurance, your spouse will not be able to return to the Plan, and may be left without group health insurance. Remember, once the waiver form is submitted, you will not be able to reverse your decision under any circumstances.

Unless you have elected to delay Plan coverage while covered under your spouse's group health plan as explained above, you may not start thereafter. If you do delay Plan coverage, your rate of payment will be based on your age at retirement, not your age when commencing Plan coverage. 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, with each deduction providing coverage for the following month.

### ***If You Return To Work...***

If you return to work after retirement (as allowed in the definition of "completely retired" on page 69) 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 family members who are eligible for Medicare incur while you are covered as an active employee. See pages 81-88 for more information on the Non-Duplication of Benefit Rules.

After your Reserve Hour Bank drops below the minimum required hours, you will revert to retiree coverage status and be covered by the benefit schedule you chose upon retiring. You cannot use this as an opportunity to change your retiree schedule or rate. Any remaining hours in your Reserve Hour Bank will be saved for the next year. Medicare is primary on claims you and your covered family members eligible for Medicare incur while you are covered as a retiree. See pages 81-88 for more information on the Non-Duplication of Benefits rules.

It is your responsibility to notify the Trust Fund Office, in writing, if you return to work.

### **Kaiser HMO Health Plan Option**

If you and your eligible spouse are in the Kaiser Health Plan and either of you are eligible, or become eligible, for Medicare, the Medicare-eligible individual must complete and submit an application in order to be covered under the Kaiser Permanente Senior Advantage Program (KPSA); otherwise, you and your dependents 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.
7. Please note that the following conditions *disqualify* a participant from participating in an HMO Medicare-Risk Program such as Kaiser Permanente Senior Advantage (KPSA):
  - a) Participants who have end-stage renal (kidney) disease.
  - b) Participants who have had a kidney transplant within the last 36 months.
  - c) Participants who are receiving Medicare Hospice benefits.

*Under California law, HMOs such as Kaiser are required to offer to continue benefits for certain individuals beyond the period of federal COBRA. You and/or your spouse may be eligible for such coverage if you pay the full cost of the continuation coverage and if certain conditions are met.*

- 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*.

**If you have any questions or would like more information regarding KPSA, please contact the Trust Fund Office, or Kaiser at (800) 464-4000.**

### **E. If You Die**

If you die while you are employed, coverage for your eligible surviving spouse and/or children will continue for as long as you have enough hours in your Reserve Hour Bank. When there are no longer sufficient hours in your Reserve Hour Bank, your surviving spouse and dependents may elect to continue coverage by making self-payments to the Plan. Your surviving spouse can continue making active self-payments for up to 12 months and then may be eligible for COBRA for an additional 24 months. If you die while you are receiving retiree benefits, coverage for your eligible surviving spouse and dependents will continue for as long as the appropriate self-payments, as determined periodically by the Board of Trustees, are made. Your surviving spouse will continue to pay the single rate in the age bracket you retired at, until your surviving spouse become Medicare-eligible.

Your surviving spouse may also elect to cover your surviving children who depend on your spouse for more than one-half of their support and for as long as they satisfy the eligibility requirements. Your spouse must enroll your eligible surviving children during the month in which he or she makes the first payment for Plan coverage. Your newborn children may become covered if an Enrollment Form is submitted within 30 days of birth or adoption. These are the only times when surviving children may be added to the Plan.

**If your surviving spouse remarries, neither (s)he nor his/her new spouse will be covered under the Plan. Newborn children and step-children from the new marriage will not be covered.**

If you or your covered spouse dies and your eligible disabled dependent is covered by the Plan at that time, he or she may continue to be covered by the Plan as a separate individual if the following criteria are met:

- your dependent is eligible for Medicare/Medi-Cal based on a determination of disability;
- your dependent is covered under the Kaiser Permanente Senior Advantage (KPSA);
- your dependent was covered as a dependent under the Plan immediately prior to reaching age 26;
- 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;
- 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, and the self-payments are continued.

### *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 stops making the monthly payments, surviving spouse 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.

### **F. COBRA Continuation Coverage**

Under federal law known as COBRA, you and your covered family members (called “qualified beneficiaries”) are entitled to continue medical, prescription drug, dental, vision, and alcohol and drug coverage under certain circumstances when coverage would otherwise end – provided you pay the full group premium plus a 2% administrative fee under most circumstances. You cannot continue life and dismemberment insurance under COBRA.

Qualified beneficiaries include you and your eligible dependents who are covered under the Plan at the time your coverage would end for one of the reasons described below. Qualified beneficiaries also include children who are born to or adopted by you while you are covered under COBRA and whom you enroll in COBRA. Individuals who decline COBRA when first eligible are not qualified beneficiaries.

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 65. In other words, your continued coverage is subtracted from the maximum COBRA coverage described below.**

You and your covered family members may elect to continue Plan coverage under COBRA for up to 18 months if your coverage ends because:

1. your employment terminates (except if you are terminated for gross misconduct), or
2. you are no longer eligible under the Plan due to a reduction in your hours of work.

Plan coverage may be continued for a covered family member for up to 36 months if his or her coverage ends due to one of the following events:

1. your death,
2. your divorce or legal separation,
3. your child no longer qualifies for dependent coverage under the terms of the Plan, or
4. your entitlement to Medicare benefits.

**It is the responsibility of a covered employee or qualified beneficiary to inform the Trust Fund Office of the occurrence of certain qualifying events within 60 days.** If the qualifying event is the divorce or legal separation of the covered Employee and spouse, or a dependent child losing eligibility for coverage *as* a dependent child (i.e., turning 26 years of age -- refer to page 5 for dependent eligibility), you must notify the Plan Administrator in writing within 60

days after the qualifying event occurs or the date on which coverage would end because of the qualifying event, whichever is later.

If, when you terminate employment or your hours are reduced, you are entitled to Medicare benefits, you will not be eligible for COBRA coverage. However, your covered family members may elect COBRA coverage for up to 36 months from the date you became entitled to Medicare, or up to 18 months from the date you terminated or your hours were reduced, whichever is longer.

You or your covered family members may extend COBRA coverage from 18 to 29 months if, when you terminate employment or your hours are reduced, or within 60 days thereafter, you or your family member is or becomes disabled as determined by Social Security. If you or your family member elects the extension, you will pay 150% of the full group premiums for the additional 11 months of coverage. You must notify the Trust Fund Office that you want the extended COBRA coverage within 60 days of the date you or your dependent is declared disabled by Social Security, but not later than 18 months from the date you or your dependent initially became eligible for COBRA coverage.

Extended COBRA coverage will end if you are no longer disabled. You or your dependent must notify the Trust Fund Office within 30 days of the date you are determined by Social Security to be no longer disabled.

When any of these events occurs, the Trust Fund Office will give you an election form and more information about the cost of coverage and payment method. You or your family member 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.

If your covered family member elects COBRA coverage due to your termination of employment or reduction in hours, he or she will be entitled to additional coverage – up to a total of 36 months – if there is a second qualifying event during the first 18 months, such as:

1. you die,
2. you divorce or legally separate,
3. your child no longer qualifies for coverage under the terms of the Plan, or
4. you become entitled to Medicare benefits.

If such a second qualifying event occurs while you or your covered family members are receiving COBRA continuation benefits, you (they) must notify the Plan in writing within 60 days of the occurrence of the second qualifying event or the date on which coverage would end because of the qualifying event, whichever is later.

Your written notice of a qualifying event must include the date of the qualifying event, i.e., the effective date of a divorce, the date on which a dependent child turned 26, or the date on which the Social Security Administration determined you to be disabled. (A copy of the notice of determination of disability by the Social Security Administration must also be included.) You may use the notification form provided to you with your initial notice of COBRA rights, or simply provide written notice in any other form so long as it includes the foregoing information. Your notice to the Plan must be mailed by first-class mail within 60 days of the qualifying event to: Northern California Sheet Metal Workers Trust, c/o BeneSys Administrators, P.O. Box 1677, San Ramon, CA 94583.

Once the Plan receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will

have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

After receiving notice of a qualifying event the Plan Administrator will send you an election form, notifying you of your COBRA rights and giving you the opportunity to elect to take COBRA. You must return the election form within 60 days, and you must send your premium (representing 102 % of the cost of your benefits) for your initial month(s) of COBRA coverage within 45 days of returning the election form. (Premiums are 150% of cost for a qualified beneficiary on a disability extension.) Thereafter, your premium *must* be postmarked no later than the last day of the month for each month for which you want coverage. *You will not receive any notice of premium due or monthly bill from the Plan, and if you are late paying any premium your COBRA benefits will be stopped and you will be unable to renew them.*

Your COBRA election form and all premium payments should be mailed to: Northern California Sheet Metal Workers Trust, c/o BeneSys Administrators, P.O. Box 1677, San Ramon, CA 94583.

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

**If you have questions concerning your Plan or your COBRA continuation coverage rights they should be addressed to the Trust Fund Office, also at this address, or to the contacts identified below.** For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office (see below) of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

Employee Benefits Security Administration (EBSA)  
Regional Office  
71 Stevenson Street, Suite 915  
San Francisco, CA 94105  
Telephone: (415) 975-4600

Employee Benefits Security Administration (EBSA)  
District Office  
1111 Third Avenue, Suite 860  
Seattle, WA 98101  
Telephone: (206) 553-4244

It is important to keep the Plan informed of address changes. **In order to protect your family's rights, you should keep the Trust Fund Office informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Trust Fund Office.**

COBRA coverage may stop on a date before the end of the 18-, 29- or 36-month period as follows:

1. The date you or your family member becomes covered under any other group health plan, unless the other plan has an exclusion or limitation for a pre-existing medical condition which will affect you or your family member's coverage.
2. The date you or your family member becomes entitled to Medicare benefits.
3. The date you fail to pay the required premium on time.
4. The date your employer is no longer obligated to contribute to the Plan.

Your benefits while you are covered under COBRA coverage will be the same as the coverage for active employees. Therefore, if there are any changes to the Plan for active employees, your benefits will also change. Your cost for coverage will not change more frequently than once each year.



## Union Support is Essential...

*if your membership lapses or you work in non-covered sheet metal service, your Plan coverage will end.*

## Union Support is Essential

The purpose of this Plan is to provide health care protection to union members and employees of Plan sponsors. If your union membership lapses or you work in non-covered sheet metal service (defined below), your coverage will end as follows.

### **If Your Union Membership Lapses**

If you fail to maintain your union membership (unless union membership is precluded to you because of your current or former employment classification) in accordance with the collective bargaining agreement which entitles you to Plan coverage, benefits for you and your family members will cease immediately, and you will forfeit the hours in your Reserve Hour Bank.

Your coverage may be reinstated if you resume your union membership in good standing within one year of its lapsing. The hours in your Reserve Hour Bank also may be restored. Retroactive coverage is permitted only if your union membership is reinstated on a retroactive basis.

This provision does not apply if you are a non-bargained employee 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 Health Care Plan or any reciprocal plan (such as the Sheet Metal Workers Local 104 Health Care 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 yourself on your own property.

Work in non-covered sheet metal service can result in a loss in your Northern California Sheet Metal Workers 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, for the second month following the month in which you engaged in non-union sheet metal service. If the Plan is not notified of your non-covered sheet metal service in time to deny coverage in this timeframe, the Trustees may, at their discretion, suspend coverage for the appropriate number of months immediately following notification.
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 requalify for active or retiree coverage.

4. *Retired Participants.* Retired participants who perform any non-qualified sheet metal service after retiring will not be entitled to self-pay in the future at any subsidized rate. Instead, you will have to pay the full cost of your coverage as determined from time to time by the Trustees.
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.

If you are retired but are thinking of returning to work, you may request an advance decision from the Trustees on whether your proposed employment will cause a suspension, reduction, or elimination of your benefits. Such requests should be made, in writing, and sent to the Trust Fund Office.



## Non-Duplication of Benefits...

*when you or your family members are eligible for benefits under this Plan as well as another plan, the benefits are not duplicated.*

## **Non-Duplication of Benefits**

When you or your family members (or an organ transplant donor on your behalf) are eligible for benefits under this Plan as well as another health plan, the two plans are blended to ensure that the combined benefits are not more than the plans were intended to pay. This provision is called "Non-Duplication of Benefits."

Here are some examples of other plans you or your family members may be covered under:

1. Other group insurance plans or health maintenance organizations, such as when you are covered as a dependent under your spouse's employer provided plan.
2. Other labor-management trusted plans, union welfare plans, employer organization plans, or employee benefit organization plans.
3. Governmental programs or programs required or provided by any law.

If you or your family members are covered under more than one group plan, one plan is primary and the others are secondary. The primary plan pays benefits before the secondary plans pay. If one plan has no non-duplication or coordination of benefits provision, it is automatically primary.

When the Sheet Metal Workers Plan is primary, it will pay the benefits described in this booklet. When the Sheet Metal Workers Plan is secondary, it will pay an amount to bring the total paid by the other plan and this Plan up to the "allowable expense." Provided, however, that the Sheet Metal Workers Plan will pay no more than it would have paid as a secondary plan, had the primary plan paid under its provisions that would apply when it is the only plan involved.

An allowable expense includes any medically necessary, reasonable and customary item or medical expense incurred, a portion of which is covered under either this Plan or one or more other plans covering the person for whom the claim is made. Any item specifically excluded from coverage under this Plan can never be an allowable expense.

Allowable expenses cannot exceed the lesser of the following:

1. the normal charge billed for the expense by the provider,
2. the contractual rate for such expense under a preferred provider contract between the provider and this Plan,
3. the contractual rate under a preferred provider contract between the provider and the plan with which this Plan is coordinating benefits,
4. of the scheduled amount for eligible expenses under this Plan for Basic hospital, surgical and medical care benefits, or
5. the scheduled amounts for other medical or vision benefits under this Plan.

### **Who Pays for What**

To determine whether one plan is primary over the other, it is necessary to determine the order in which the various plans will pay benefits.

1. The plan which covers you as an employee or retiree will pay benefits before the plan which covers you as a family member.

2. For your dependent child, the plan of the parent whose birthday falls earliest in the year will pay benefits before the other parent's plan. If one of the plans does not contain this "birthday rule," then the father's plan will pay benefits first.
3. For a dependent child, if you and your spouse are divorced or separated, benefits will be paid in the following order:
4. If the court has established one parent as financially responsible for the child's health care, the plan of the parent with that responsibility will pay benefits first;
5. Then, the plan of the parent who has custody of the child;
6. Then, the plan of the spouse of the parent who has custody of the child;
7. Then, the plan of the parent who does not have custody of the child.
8. The plan which covers you as an active employee will pay benefits before the plan which covers you as a retiree.
9. If none of the above situations apply to you or your dependent, the plan which has covered you or your dependent for the longer period of time will pay before the plan which has covered you for a shorter period of time.

### **Medicare and Your Benefits**

If you are an active employee age 65 or older, this 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 family members and organ transplant donors on your behalf.

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 family members and organ transplant donors on your behalf.

**If you are a *retired employee***, the Plan integrates benefits with Medicare as if you are covered under both Medicare Part A (hospital benefits) and Part B (supplemental medical benefits) whether or not you have applied for, or are enrolled in, Medicare benefits. This means if you do not enroll in Medicare, the Plan will not make up for the portion of expenses that Medicare would have paid had you enrolled.

If you are an *active employee*, **the Plan integrates benefits with Medicare as if you are covered under Medicare Part A (hospital benefits) whether or not you have applied for, or are enrolled in Medicare benefits. However, you are not required to enroll in Medicare Part B (supplemental medical benefits) if you have acknowledged in writing that you are aware of the consequences of not enrolling in Medicare Part B by your 65th birthday. You can request a form for this purpose from the Trust Fund Office.**

**Medicare Part D**—if you are a Medicare-eligible retiree in Schedule 1 or 1A, 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 Northern California Sheet Metal Workers 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.

If you are enrolled in Schedule 7, your benefits do not include prescription drug coverage and you should consider enrolling in Medicare Part D for your prescription drug coverage. You can enroll in Medicare Part D when you become eligible (e.g., when you lose creditable coverage) and each year between October 15th through December 7th. You will be required to pay a penalty as part of your monthly premium if you delay your enrollment. You can get information about Medicare Part D plans in the “Medicare & You” handbook you will receive in the mail every year from Medicare, by visiting [www.medicare.gov](http://www.medicare.gov) or calling 1-800-MEDICARE (1-800-633-4227) (TTY users should call 1-877-486-2048).

*Please note that whether or not you are advised to enroll in Medicare Part D, you must still enroll for Medicare Part A (and Part B, unless you have filed a written acknowledgment with the Trust Fund Office) in order to get full coverage in the Health Care Plan.*

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—just like any other eligible expense. In other words, these unpaid expenses will be treated as a medical expense that is covered by the Plan. Usually, Medicare pays up to 80% of Medicare-approved charges. The Plan will also pay up to 100% of the remaining Medicare-approved charges after Medicare pays its portion of the benefit. The Plan will never pay more than the Medicare-approved amount for Medicare-covered services. This means that you will have less to pay out of pocket when you receive Medicare-covered services.

For example, if you have \$1,000 in eligible expenses and Medicare pays \$800, the remaining \$200 will be covered by the Plan in accordance with Plan rules. Like other expenses, the covered amount will be subject to the Plan’s deductible (if applicable) and the regular payment levels, the scheduled maximums and usual and customary limits, as well as the Plan’s limitations and exclusions.

As you can see, you will receive a benefit payment from the Plan for a portion of the eligible expense not paid by Medicare, unless the amount is less than the Plan’s annual deductible or the treatment is not an eligible expense under the Plan.

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

If you are enrolled in Kaiser, please note that Kaiser offers different plans to participants on Medicare.

### **About Medicare**

Medicare benefits are not automatic; you must apply for them in order to be covered. Medicare benefits are available from 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.

In order to get full protection, you should enroll for Part A and Part B of Medicare during the three months before you or your family member reaches age 65.

The law allows you to delay enrollment in Medicare Part B without penalty provided:

1. You or your spouse remains actively employed and covered under you or your spouse's employer-provided group health plan (whether a Trust sponsored group health plan or another group plan).
2. You elect Medicare Part B coverage within a seven-month "special enrollment period" which begins three months before the month in which you or your spouse is no longer covered under an employer-provided group health plan through active employment.

If you want to delay Medicare Part B coverage *while you are still working*, you **MUST** confirm your intent to delay coverage on a form available upon request from the Trust Fund Office. You may be subject to penalties and lesser benefits if you do not enroll in Medicare Part B when you are retired.

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

### **Third Party Recovery Provision**

#### **Right of Subrogation and Refund**

**When this provision applies.** A Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses gives the Plan the right to take an assignment of any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan also has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full, and any such Recovery by the Covered Person, including any portion of the Recovery designated for payment of attorney's fees, shall be held in constructive trust for the Plan up to the full amount of payments made by the Plan that it is entitled to recover.

The Covered Person:

1. must assign to the Plan his or her rights against any Third Party or insurer at the Plan's request when this provision applies; and
2. must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

**Amount subject to Subrogation or Refund.** The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over *any* and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for

medical or dental expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

**Conditions Precedent to Coverage.** The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. The Plan may require a Covered Person to agree to acknowledge in writing the Plan's right to reimbursement before it will pay claims for expenses incurred because of an illness or injury for which a Third Party is (or may be) responsible. If a Covered Person fails to reimburse the Plan as required by this provision, the Plan may either deny payment of benefits and/or offset future benefits otherwise payable to or on behalf of the Covered Person against the amount to which it is entitled to be reimbursed until the full amount owed to the plan is paid. Further, in the event the Covered Person is a minor, the Plan may deny payment of any medical or dental benefits incurred on account of Injury or Sickness caused by a Responsible Third Party until after the Covered Person or his authorized legal representative obtains valid Court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

**Defined terms:** "Covered Person" means any person covered under the Plan, including minor dependents.

"Recoveries" means all monies paid to, or to another party on behalf of, the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees (including fees paid directly to attorney), costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

**Recovery from another plan under which the Covered Person is covered.** This right of Refund also applies when a Covered Person recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

**Rights of Plan.** The Plan has the right to request reports on and approve of all settlements before they become final.

## **Employment-related Injuries or Illnesses**

The Plan does not pay benefits for injuries or illnesses you or your family member incurs on-the-job, subject to the following:

1. You or your family member will be presumed to be an employee of the employer (as defined under applicable Workers' Compensation laws), regardless of actual employment status.
2. This provision applies whether or not your or your family member's employer has Workers' Compensation insurance that pays for the particular medical expenses.
3. The Plan will pay benefits under the following conditions:
  - a. If the Plan determines that it can collect the claim covered by a Workers' Compensation insurance policy or another collection arrangement.
  - b. If you or your family member assigns to the Plan all rights to medical reimbursement under the applicable Workers' Compensation laws. When you or your family member accepts payment from the Plan, you also agree to allow the Plan to recover payments received from Workers' Compensation. You or your family member may be required to sign forms to that effect. Failure to sign the forms will make you or your family member ineligible for any Plan benefits related to the Workers' Compensation claim.
4. The Plan may intervene in any legal action you or your family member brings under the Workers' Compensation laws. In addition, the Plan may collect money directly from an employer or Workers' Compensation carrier by filing a lien on the proceeds with your or your family member's employer, its insurance carrier, its other agents, or the tribunal deciding Workers' Compensation claims.
5. If you or your family member settles or makes a compromise on a Workers' Compensation claim so that the amount the Plan is reimbursed is less than the lien, or so that the employer or its insurance carrier is relieved of any future liability for medical expenses, then you or your family member will not receive any benefits from the Plan in connection with the medical condition related to that Workers' Compensation claim, unless the settlement has been pre-approved in writing by the Board of Trustees or its representative.
6. When you or your family member accepts payment from the Plan, you also agree to not prejudice the Plan's rights to reimbursement under any applicable Workers' Compensation laws.
7. The Plan will pay benefits for follow-up examinations on asbestosis-related cases until you or your covered family member 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 under California's Workers' Compensation laws.

Before the Plan pays benefits for follow-up examinations, you or your covered family member must sign forms allowing the Plan to recover payments made to you or your family member by Workers' Compensation. However, whether or not the forms are signed, if you or your family member develops an asbestosis related disability and a Workers' Compensation claim is awarded, you or your family member 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.

## **The Trust Fund Office's Right to Receive and Release Information**

Certain facts are needed to administer these coordination of benefit, third party liability and Workers' Compensation rules. Each person claiming benefits under this Plan must provide any facts or information needed to pay the claim in question. In addition, you or your family member may be required to give written authorization to the Trust Fund Office to obtain the information it needs to complete a claim.

## **Overpayments And Right To Recover Benefits**

The Plan checks all claims to be sure the patient is eligible for benefits and the services or supplies were provided. The Plan reserves the right to provide or obtain any information needed to determine benefits, without the consent of any person. If an overpayment is made as the result of a coordination of benefits error or for any other reason, the Plan reserves the right to recover the amounts overpaid from you or from the benefit plan, insurance company, organization or provider to whom the overpayment was made. If an overpayment has been made to, or on behalf of, you or your spouse and you do not promptly pay back the overpaid amount to the Plan, the Plan may also recover the overpayment by deducting it from any future benefits payable to you or assigned by you. The Plan is not required, but reserves the right, to make restitution to another plan that has overpaid, and this payment is considered a benefit payment under the Plan made on your behalf.

Based on the specific circumstances particular to how a claim is submitted, the Plan may pay benefits before resolving whether or not such care is actually covered; this does not mean that the Plan exclusions were waived. If it is found that such a care is not covered, the Plan may require the covered person and/or provider of services to repay any overpayment.

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. Any incident involving fraud also may be referred to legal authorities for criminal prosecution. If you are convicted, you could be required to pay a monetary penalty and serve time in prison for each false statement or omission.

If you submit false information in connection with a benefit claim, the Plan may in addition to seeking recovery of the overpayment, also withhold benefits otherwise payable to you and your family until it has recouped any overpayments made as a result of relying on the false information. **A false statement includes, but is not limited to, the concealment or omission of material information, such as a divorce, a child's loss of eligibility or change in marital status. It is not necessary that you did not intend to defraud the Plan for it to recoup overpayments in this manner.**

If the Plan does not follow these rules for a claim, this does not mean that the Plan has waived the Board of Trustees' right to invoke these rules for other claims.



## Applying For Benefits...

*when and where to submit your claims for benefits.*

## Applying For Benefits

### **Claims Procedure**

If you are enrolled with Kaiser, you do not need to file claims for medical or prescription benefits unless you receive emergency or urgent care from a non-Kaiser provider, in which case, you should submit a claim directly to Kaiser.

If you receive services from a PPO provider, that provider will send a claim to the Plan on your behalf. If you must submit a claim yourself, claims for Indemnity Medical Plan, prescription drug or dental benefits should be submitted on a claim form provided by the Trust Fund Office. The Trust Fund Office must receive your claim within 12 months of the date you receive the service or supply or it will be denied.

Each claim should include the full name of the patient, the diagnosis, the treatment date, the type of treatment or service received, and the doctor's name and address. Canceled checks or balance due bills are not acceptable. If the Northern California Sheet Metal Workers Health Care Plan is the secondary payor, you must submit a copy of the primary payor's explanation of benefits (EOB) form.

When you receive health care for eligible expenses, you should:

1. Get a claim form from your employer, your local union or the Trust Fund Office.
2. Have your doctor or dentist complete his or her portion of the form.
3. Complete your portion of the form.
4. Attach all itemized bills relating to the claim to the completed claim form. Incomplete forms and unitemized bills will delay the processing.

Submit claim forms for medical services to:

Northern California Sheet Metal Workers Health Care Plan  
c/o Blue Shield of California  
P.O. Box 272540  
Chico, CA 95927-2540

Submit claim forms for other benefits (including TARP) to:

Northern California Sheet Metal Workers Health Care Plan  
c/o BeneSys, Inc.  
P.O. Box 1138  
San Ramon, CA 94583-1138

Before the Plan pays benefits, the Trust Fund Office may ask you to be examined by a doctor of its choice. The Plan will pay for these examinations.

In most cases, the Plan will pay your benefits directly to your health care provider.

If you are not living when the Plan would otherwise pay benefits to you, then the benefits will be paid to your estate. If your beneficiary is a minor or otherwise incompetent, the Plan will pay up to \$1,000 in benefits to your beneficiary or your beneficiary's relative who the Plan deems to

be entitled to the payments. See page 57 for special provisions that apply under the life insurance plan.

If an overpayment of a claim is discovered, you will be asked to reimburse the Trust Fund Office in the amount of the overpayment.

### **Appeals Procedure**

If your claim is denied in whole or in part, you will receive within 30 days after filing the claim (or in less time if an urgent care or non-urgent, pre-service claim is involved) a written explanation from the Trust Fund Office stating the reasons for the denial, the specific references in the Plan's document that support these reasons, any additional information you must provide to improve your claim, and the procedure available for further review of your claim.

If you do not agree with the Plan's denial of your claim, you may appeal the denial in writing within 180 days. You or your representative may review the Plan documents and other documents pertaining to the denial of your claim, and you may submit written comments explaining why you believe the claim was denied in error. If your appeal involves an ongoing course of treatment, the Plan will continue to provide coverage while your appeal is pending.

The Board of Trustees or a committee of the Board will conduct a full and fair review of your denied claim. Generally, the review will be held and a decision made by the next regularly scheduled Trust meeting, unless the appeal is received within 30 days of such meeting or other special circumstances require additional time. If special circumstances require an extension of time, the decision will be made no later than the third meeting following receipt of the appeal. You will be notified of the decision within five days following the decision, with regard to most claims. (In the case of an appeal of a non-urgent, pre-service claim, a decision will be made within 30 days of receipt of your appeal; in the case of an appeal of an urgent care claim, a decision will be made within 72 hours of the receipt of the appeal.)

### **External Review of Claims**

If the Trustees deny your appeal, you may, within four months of the date you were notified of the denied appeal, make a written request for an external review of your claim by an Internal Review Organization (IRO). You may also request external review within four months of a denied claim if the conditions for expedited review are met.

The Plan will initially review your request for external review to determine whether it is eligible for review if you have not exhausted your internal appeal or your claim involves a determination that you have not met the eligibility requirements of the Plan. The Plan will inform you of any issues with your request. If your request is eligible for review, but incomplete, you will be informed what information is required to complete the request and you will be given the longer of 48 hours or the remainder of the four-month filing period to correct the deficiency.

If you request external review, your claim will be submitted to an accredited IRO together with any documents and information the Plan and Trustees relied upon in considering your claim and internal appeal. You will be informed by the IRO when it has received your claim and provided ten days to submit any additional information in support of your appeal. If you submit new information, the IRO will share that information with the Board of Trustees, which may reconsider your internal appeal.

The IRO will make independent medical and legal decisions concerning your claim and issue its decision within 45 days of receiving your claim for review. If the IRO decides that the Plan

must provide additional benefits, the Plan will carry out the decision but may challenge the decision by bringing suit against any necessary parties. If the IRO determines that the internal appeal was correctly decided, you may bring legal action against the Plan within one year of the IRO's decision.

**Expedited External Review.** You may request expedited external review by an IRO if (a) you simultaneously request an expedited appeal to the Board of Trustees and your claim involves a medical condition for which the timeframe for completion of an expedited appeal to the Board of Trustees would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function; or (b) you have received an appeal denial that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or (c) you received a claim denial that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility. The Plan will review your request immediately to determine whether it is eligible for external review. If it is eligible, your claim will be referred as soon as possible and you will receive written confirmation of the decision.

### **Legal Action Against Plan**

You are not required to seek external review by an IRO and may instead challenge the Trustees' denial of an appeal by bringing legal action against the Plan within one year of the date you are informed your appeal has been denied. No legal action challenging a claim denial may be brought against the Plan after the later of one year from (a) the date your internal appeal to the Board was denied or (b) the date the IRO determined the internal appeal was correctly decided. You must exhaust your right of appeal described in this section before bringing suit against the Plan or Trustees.

The Trustees have sole authority to interpret the provisions of the Plan and to interpret the rules and benefits of the Plan and their good faith interpretations of the rules, benefits and provisions of the Plan shall be final and binding, subject to the provisions of ERISA.

### **Plan Change Or Termination**

The Trustees reserve the right to change or discontinue the types and amounts of benefits under the Plan, the Plan's eligibility and other rules, the amount of contributions required for participation and all other aspects regarding the Plan.

Plan benefits and eligibility rules are not guaranteed or vested, may be changed or discontinued by the Board of Trustees, are subject to the rules and regulations adopted by the Board of Trustees, and are subject to the applicable collective bargaining agreements and the Trust Agreement which established and governs the Trust's operation.



## Your Legal Rights And Administrative Information About The Plan

## **Compliance with HIPAA Privacy Regulations**

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the Department of Health and Human Services has adopted regulations for group health plans to treat health information of participants and beneficiaries as protected information. The application of those regulations to the Plan is summarized here. You may also request a copy of the Plan's Notice of Privacy Practices from the Trust Fund Office.

Information regarding a person's past, present or future physical or mental health, the provision of health care to that person, or past present or future payment for that person's health care, known as "Protected Health Information" (PHI), can be disclosed only to certain individuals for specific purposes.

The Plan Sponsor for the Northern California Sheet Metal Workers Health Care Plan is the Joint Board of Trustees of the Plan. The Joint Board of Trustees consists of an equal number of Union and Management Trustees whose Unions, Companies and Associations are party to collective bargaining agreements that provide for participation in the Plan. The Plan Sponsors have final authority over Plan administration and operations, and in order to meet their obligations in this regard, must have access to PHI.

### **Disclosure of Protected Health Information (PHI) to the Plan Sponsor for Plan Administration and Operations**

The circumstances and purposes for which the Plan Sponsor may have access to PHI regarding you or your covered dependents are as follows:

1. Deciding appeals of benefit denials and eligibility; establishing contribution rates; making determinations regarding benefits, including whether or not to offer certain benefits and making plan design decisions; monitoring services provided by, and contracting with, HMOs, insurers, provider networks, and providers themselves (i.e., doctors and hospitals).
2. Dealing with subrogation and reimbursement claims involving third parties and participants; addressing coordination of benefit issues with other plans; purchasing stop-loss insurance and/or insurance to cover any of the benefits offered by the Plan.
3. Making decisions regarding the interpretation of plan documents as they relate to specific benefit claims, including decisions regarding medical necessity, disease management, standards of practice, and experimental treatments.
4. Providing for the collection of contributions from participating employers, including the auditing of such employers and the subsequent review of compliance audits to determine which employees and dependents an employer has contributed for and if there are any for whom contributions are delinquent.
5. Addressing issues and appeals involving participants' legal rights, such as COBRA continuation coverage, HIPAA special enrollment periods, and HIPAA certificates of creditable coverage.

## **Disclosure of PHI to Plan Consultants**

The Joint Board of Trustees acting as Plan Sponsor, undertake their responsibilities to the Plan on a voluntary basis. They are not employed by the Plan, nor does Plan or the trust fund have any employees. The Trustees and the Plan therefore utilize outside consultants to assist in all aspects of plan administration and operations, which requires the Plan to disclose PHI to them.

The consultants retained by the Plan include attorneys, benefit consultants, accountants, auditors, and the third party administrator that administers the plan. Any or all of them may require access to PHI in order to advise and assist the Trustees. For example, the third party administrator for the Plan, which processes all claims and verifies eligibility, will have access to PHI in carrying out these administrative functions. The auditor for the Plan determines if contributions have been correctly paid for all covered employees, and if ineligible persons were covered, whether claims were paid for them based on improper employer contributions.

## **Certifications, Restrictions and Limitations on the Use of PHI**

The Plan, and the Plan Sponsor, hereby certify that they will:

- a) Disclose PHI to the Plan Sponsor and its consultants only as set forth above and only the minimum amount necessary to enable them to fulfill their obligations to the Plan and its participants.
- b) Report to the Plan any unauthorized disclosure of PHI or any use of PHI that is contrary to the purposes set forth herein. If the Plan Sponsor wishes to obtain access to PHI for purposes other than those set forth herein, it will seek written authorization from the participant(s) whose PHI is involved before the Plan allows access to the information.
- c) Ensure that all consultants, attorneys, accountants, auditors, third party administrators, HMOs, insurers, or other Business Associates of the Plan agree in writing not to disclose or use PHI for any purpose contrary to law or to the terms of such written agreement with the Plan, and to otherwise comply with the requirements of the Privacy Standards with regard to the use and disclosure of PHI.
- d) Make the PHI of any participant available to them pursuant to Section 164.524 of the Privacy Standards (45 CFR 164.524).
- e) Not use or disclose PHI for employment related actions or decisions or in connection with any other non-group health employee benefit plan of the plan sponsor.
- f) Make available PHI for amendment, and incorporate any amendments to PHI, in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526).
- g) Make available an accounting of disclosures of PHI to any participant in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528).
- h) Make the Plan's internal practices, books and records relating to the use or disclosure of PHI available to the Secretary of HHS for audit purposes.
- i) If feasible, return or destroy all PHI received from the group health plan that the plan sponsor retains in any form when no longer needed for the purpose for which the disclosure was made.
- j) Ensure that adequate separation between the group health plan and the plan sponsor exists to ensure the confidentiality of PHI.

- k) Make no other disclosures or uses of PHI besides those permitted or required by the Plan Documents or as required by law.

### **Privacy Officer**

The Plan has appointed a Privacy Officer, who is designated to ensure that this policy is followed and to address any issue or complaint regarding access to PHI for the Plan. Any participant or beneficiary who has a question or concern regarding the use of their PHI may direct their question or concern to: Privacy Officer, Northern California Sheet Metal Workers Trust, c/o BeneSys Administrators, P.O. Box 1677, San Ramon, CA 94583; telephone: (925) 208-9992. Participants and beneficiaries are also entitled to obtain an accounting of any disclosures of their PHI by the Plan. If they are not satisfied after communication with the Privacy Officer, they may direct any problem, concern or request to the Joint Board of Trustees, who will respond accordingly.

## **Continued Coverage Under Family and Medical Leave Act**

This Plan shall at all times comply with the Family and Medical Leave Act (FMLA) of 1993 and its equivalent under state law, the California Family Rights Act (CFRA). Your employer will normally be covered by the FMLA and the CFRA if it employs at least 50 employees at one location, or at more than one location within a 75-mile radius. If that is the case and if you meet the eligibility requirements under the FMLA and CFRA, your employer may be required to allow you to take up to 12 weeks of unpaid leave in a year due to your own serious medical condition or to care for a spouse, child or parent with a serious medical condition.

If you are off on FMLA/CFRA leave due to your own medical condition, this Plan will maintain your coverage for up to three (3) months at no cost to you, other than any employee contribution that you would normally pay. If you are off in order to care for a spouse, child or parent covered by FMLA or CFRA, your employer is obligated to pay for up to three (3) months of additional coverage for you, subject to your paying your normal contribution, if any.

## **ERISA Rights And Administrative Information About The Plan**

### **Rights Of Participants And Beneficiaries**

As a participant in the Northern California Sheet Metal Workers 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 shall be entitled to:

### **Receive Information About Your Plan and Benefits**

Examine, without charge, at the Trust Fund Office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

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

Receive a summary of the plan's annual financial report. The Trust Fund Office is required by law to furnish each Participant with a copy of this Summary Annual Report.

### **Continue Group Health Plan Coverage**

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

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 in your coverage. Note that for plan years beginning on or after January 1, 2014, insurers are prohibited from imposing pre-existing condition exclusions under the Affordable Care Act, and plans will not be required to issue certificates of creditable coverage beginning December 31, 2014.

### **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 the employee benefit 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 (pension, welfare) benefit or exercising your rights under ERISA.

### **Enforce Your Rights**

If your claim for a (pension, 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 control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The

court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### **Assistance with Your Questions**

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

### **Name of Plan**

The name of this Plan is the Northern California Sheet Metal Workers Health Care Plan.

### **Type of Plan**

This is a Health Care Plan, providing eligible participants the following kinds of benefits:

Hospital, Medical and Surgical Benefits

Alcohol and Drug Treatment Benefits

Prescription Drug Benefits

Dental Benefits

Vision Care Benefits

Death and Dismemberment Benefits

Certain employees and their family members are not eligible for the Vision Care, Prescription Drug and Dental Benefits. See the chart on page 2 for a list of the benefits included in the Benefit Schedule that applies to you.

### **Plan Administration**

The Plan is administered by a Board of Trustees consisting of an equal number of Union and Employer Trustees. Union Trustees are representatives of Sheet Metal Workers Local 104, District 2. Employer Trustees are contributing employers and representatives of the SMACNA Chapters which are signatory to collective bargaining agreements which provide for contributions to the Plan.

The Trustees have many powers and functions including adopting Plan rules and regulations to guide them in administering the Plan, interpreting Plan provisions and rules, amending the Plan, deciding questions of policy, investing and safeguarding Plan assets and appointing advisors and consultants, such as an auditor, benefits consultant, professional plan administrator, legal counsel and investment manager.

The Trustees have contracted with BeneSys Administrators, a professional plan administration firm, for the day-to-day administration of the Plan. The Trustees also use the services of a benefits consulting firm, Kaufmann & Goble Associates, to assist in determining the health care benefits provided under the Plan, among other responsibilities.

***Address of Board and Trust Fund Office:***

Board of Trustees of the Northern California  
Sheet Metal Workers Health Care Plan  
c/o BeneSys Administrators  
2610 Crow Canyon Road, Suite 200  
San Ramon, CA 94583

***Telephone:***

(925) 208-9992  
(866) 787-0162

**Other HMOs and Insurance Issuers Providing Benefits**

**BeneSys Administrators** provides only administrative services for the Health Care Plan. In this role, BeneSys determines eligibility, processes claims and issues explanation of benefit (EOB) statements to Plan participants. Under this type of arrangement, benefits are not guaranteed under a contract or policy of insurance. Questions regarding BeneSys may be directed to:

BeneSys Administrators  
P.O. Box 1677  
San Ramon, CA 94583  
(925) 208-9992 or (866) 787-0162

**Kaiser Permanente Health Plan, Inc. is an HMO that is offered as an alternative** to beneficiaries for health benefits. Kaiser provides benefits as described in its own, separate plan description and in its *Evidence of Coverage*, which is provided to those electing Kaiser. Kaiser will make determinations independent of the Trust regarding benefits provided under its plan description. Questions or problems regarding Kaiser benefits can be directed to:

Kaiser Foundation Health Plan – Customer Service  
P.O. Box 210004  
Stockton, CA 95210  
(800) 464-4000

**Envision Rx Options, Inc. administers the prescription drug benefit** under the terms of the Plan, pursuant to a contract with the Trust. Envision makes determinations regarding eligibility and benefit coverage. Such determinations, however, are subject to review by the Trustees of the Trust. Questions or problems regarding prescription drug benefits may be directed to BeneSys or:

Envision Rx Options, Inc.  
2181 E. Aurora Rd, Suite 201  
Twinsburg, OH 44087  
(800) 361-4542

**The Teamsters Alcohol and Drug Rehabilitation Program (TARP)** administers the drug and alcohol abuse treatment benefits under the terms of the Plan, pursuant to a contract with the Trust. TARP makes determinations regarding the appropriate treatment plans for drug and alcohol abuse and for placement of participants in inpatient facilities. Determinations regarding eligibility and drug and alcohol abuse benefits are subject to final review by the Trustees of the Trust. Questions or problems regarding drug and alcohol abuse treatment benefits may be directed to BeneSys or:

TARP

1620 North Carpenter Road, Suite C12

Modesto, CA 95351

(800) 522-8277 or (209) 572-6966

## **Members of the Board of Trustees**

The names and business addresses of the members of the Board of Trustees are listed below.

### **MANAGEMENT TRUSTEES**

**Jim Conway, Co-Chair**  
SMACNA - Central Valley  
SMACNA - Northern San Joaquin  
P.O. Box 1100  
Danville, CA 94526

**Rob Bell**  
New England Sheet Metal Works  
2731 South Cherry Ave.  
Fresno, CA 93706

**Richard Cooke**  
ABM  
5725 Alder Avenue  
Sacramento, CA 95828

**Dustin Saccone**  
Comfort Air, Inc.  
P.O. Box 1969  
Stockton, CA 95201

### **LABOR TRUSTEES**

**Dennis Canevari, Chair**  
Sheet Metal Workers Local 104  
2840 El Centro Road #110  
Sacramento, CA 95833

**Mike Lopez**  
Sheet Metal Workers Local 104  
5410 East Horne Avenue  
Fresno, CA 93727

**Sal Rotolo**  
Sheet Metal Workers Local 104  
2441 Station Drive  
Stockton, CA 95215

**Rick Werner**  
Sheet Metal Workers Local 104  
2610 Crow Canyon Road, Ste. 300  
San Ramon, CA 94583

### **Plan Year**

The Plan's fiscal year ends on December 31.

### **IRS Employer Identification Number**

77-6113549

### **Plan Number**

501

### **Type of Administration, Method of Funding, Contributions and Collective Bargaining Agreements**

Contributions are paid by employers and made according to the collective bargaining agreements between union locals and employers (or other types of written agreements between employers and the Trustees) on a cents-per-hour basis. In some cases individuals may be able to continue coverage by paying for it. Copies of these agreements are available to you at the Trust Fund Office. The Trust Fund Office also will give you information as to whether a particular employer or local union is participating in the Plan, and the address of a particular participating employer or local union. Assets of the Plan are held in trust, and benefits are funded through this Trust Fund.

## **Funding Medium**

The Trustees have contracted with several investment firms for the prudent investment of the Plan assets. The Trustees monitor the Manager's investments regularly. Plan assets are maintained with Bank of New York. Moreover, the Plan's auditor performs an annual audit of the Plan's financial condition.

All Plan benefits are provided directly from the Trust Fund, except for those eligible employees who elect to be covered by the Kaiser Permanente Health Plan. The Kaiser Permanente Health Plan receives premiums from the Trust Fund to provide Hospital, Medical, Surgical, and Prescription Drug benefits for employees and their family members who elect to be covered by that plan.

## **Agent for Service of Legal Process**

Board of Trustees of the Northern California  
Sheet Metal Workers Health Care Plan  
2610 Crow Canyon Road, Suite 200  
San Ramon, CA 94583

or

any Plan Trustee

## **If You Have Questions**

If you have any questions about the Plan, you should call the Trust Fund Office at:

(925) 208-9992 or (866) 787-0162

# APPENDIX A

## Definition of Terms

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### 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. Cosmetic surgery is not covered under the Plan.

### 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

Deductible means the amount you owe each calendar year for health care services covered by the Plan before the Plan begins to pay. For example, if your deductible is \$1000, you must pay this amount out of pocket before the Plan will pay benefits. 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.

### DENTIST

A Dentist is a duly licensed dentist legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed.

### DISABILITY, TOTAL

A physical or mental condition for which you need a doctor’s care and which prevents you from performing your regular duties as an employee or any employment for wages or profit, or prevents your covered dependent from doing the regular and customary activities for a person of the same age.

For you, a total disability means all periods of disability from the same condition. If you recover from this condition and return to active work that is covered by the plan for a period of at least two weeks, any later period of disability, even from the same condition, is considered a new disability.

For your dependents, a total disability means all periods of disability from the same condition. If your dependent recovers and can resume the normal activities of a person in good health of the same age for a period of six months or longer, any later period of disability, even if it results from the same condition, is considered a new disability.

Disabilities related to commission of a felony, or due to injury or illness related to military service, do not qualify as total disabilities.

Note that a different definition of disability applies to COBRA continuation coverage.

## **EMERGENCY CARE**

An emergency is defined by the Plan as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (a) a condition placing the health of an individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

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; (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; and
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**

Home Health Care means services provided by a Medicare-qualified home health agency which is primarily engaged in providing home based skilled nursing services and other therapeutic services under the supervisions of professional personnel including at least one Physician and nurse.

## **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. A continued availability of medical supervision and/or other medical consulting staff.
  - b. The continuing availability of licensed nursing personnel.
  - c. 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 charges 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 AND SUPPLIES**

Services or supplies which are provided by a hospital, doctor or other approved provider and which are determined by the Plan to be:

1. Appropriate and reasonably required for the diagnosis, treatment or management of a medical symptom, illness, injury or condition and are not cosmetic in nature,
2. The most efficient and economical service which can safely be provided for the diagnosis or the direct care and treatment of the illness, injury or condition,
3. In accordance with the standards of good medical or dental practice, and
4. Not primarily for the convenience of the person or the person's doctor or other provider.

The treatment must be one that cannot be excluded without adversely affecting the patient's condition. Furthermore, the fact that a doctor or dentist may prescribe, order, recommend or approve a service or supply does not of itself make such a service or supply medically necessary, even though it is not specifically listed as not covered by the Plan. 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 ILLNESS OR DISORDER**

The term "Mental Illness or Disorder" means any mental illness 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.

Examples of mental illnesses 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.

## **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, Envision Rx Options for the pharmacy network, TARP for alcohol and substance abuse, Blue Shield for utilization review and case management A directory of preferred providers may be obtained from the Trust Fund Office.

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, TARP, Envision Rx Options, 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 (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.
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.

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

Usual, Customary and Reasonable means the amount the Plan allows as payment for eligible Medically Necessary Services or supplies.

- With respect to a Preferred Provider Organization (PPO), the negotiated fee/rate set forth in the agreement between the PPO and the Preferred Provider network or the Plan. If such an agreement does not contain a negotiated fee/rate or a method for determining the payable amount, the charge shall be treated as though submitted by a non-PPO provider.
- With respect to a non-PPO provider, the Usual, Customary and Reasonable amount is determined by the Plan or its designee to be the lowest of (1) or (2) below that the Plan has determined it will allow for eligible Medically Necessary Services or supplies performed by non-PPO providers.
  1. For medical claims incurred in the United States, the Plan has adopted for this purpose the schedule used by Context 4 Healthcare to determine the customary and reasonable charge applicable to non-PPO providers.
  2. The provider's actual billed charge.
- For a PPO provider whose network contract stipulates that they do not have to accept the network negotiated fee/rate for claims involving a third-party payer, including but not limited to auto insurance, workers' compensation or other individual insurance, or where this Plan may be a secondary payer, the Usual, Customary and Reasonable amount under this Plan is the negotiated fee/rate that would have been payable by the Plan had the claim been processed as a PPO claim.

Except as noted above, the Plan's Usual, Customary and Reasonable amount applicable to non-PPO providers is not based on or intended to be reflective of fees that are or may be described within the healthcare industry as usual and customary (U&C), reasonable and customary (R&C), prevailing or any similar term. The Plan's definition of Usual, Customary and Reasonable set forth above shall prevail to the extent it conflicts with any other usage of "usual, customary and reasonable charge" or "UCR" used in the healthcare industry. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim.

## APPENDIX B

### Out of Area Programs

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#### OUT OF AREA PROGRAMS

Benefits will be provided for Covered Services received outside of California within the United States, Puerto Rico, and U.S. Virgin Islands. The Plan calculates the Participant's Copayment either as a percentage of the Allowable Amount or a dollar Copayment, as defined in this Summary Plan Description (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 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 Plan for payment. The Plan will notify you of its determination within 30 days after receipt of the claim. The 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 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](http://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 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 Trust Fund Office 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](http://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 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.

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