

**SHEET METAL WORKERS' LOCAL 7-ZONE 3  
BENEFIT FUNDS**

**P.O. Box 547  
Troy, MI 48099-0547  
(248) 641-4973 (800) 451-5733**

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**Important Changes to the  
Sheet Metal Workers Local 7 Zone 3 Health and Welfare Plan**

This Summary of Material Modifications (SMM) is being sent to all active and retired members who participate in the Sheet Metal Workers Local 7 Zone 3 Health and Welfare Plan (Plan). It is intended to advise you of changes to your Plan. Please take the time to read this carefully and keep it with your Summary Plan Description (SPD). If you have any questions regarding the Plan, please do not hesitate to contact the Fund Office.

**Protections from Surprise Medical Bills**

Effective May 1, 2022, you will have protection against surprise medical bills from out-of-network providers and facilities under a new federal law called the No Surprises Act. This law mainly applies to Out-of-Network **Emergency Services**, services provided by out-of-network providers at network facilities, and Out-of-Network **Air Ambulance Services**.

Terms that are bolded throughout this Notice are defined in the Definitions section below.

*Out-of-Network Emergency Services*

Covered **Emergency Services** are treated as In-Network for determining all cost-sharing amounts, including the coinsurance, copayments, deductible, and the out-of-pocket maximum, even if the services were received from an **Out-of-Network Emergency Facility**. This means you will be responsible for the network cost-share amount. The Plan will count any cost-sharing payments toward the in-network deductible and/or the in-network out-of-pocket maximums in the same manner it would count cost-sharing payments made for in-network **Emergency Services**.

Your cost-sharing will be based on the **Recognized Amount** payable for these services.

If you receive **Emergency Services** from an out-of-network provider, the provider is not permitted to “balance bill” you for the difference between what the provider charges and the total amount collected by the provider, which include payments paid by the Plan and copayments, coinsurance, or deductible amounts paid by you.

*Out-of-Network Providers at Network Facilities*

Unless you consent to receiving services from the out-of-network provider (as described in this section), covered services performed by out-of-network providers with respect to visits at network facilities are treated as in-network for determining all cost-sharing amounts, including the coinsurance, copayments, deductible, and the out-of-pocket maximum. This means you will be responsible for the network cost-share amount, and the Plan will count any cost-sharing payments incurred for these services toward the in-

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network deductible and/or the in-network out-of-pocket maximums under the Plan in the same manner it would count cost-sharing payments made for in-network services.

Your cost-sharing will be based on the **Recognized Amount** payable for these services.

If you receive services from an out-of-network provider at a network facility, the provider is not permitted to “balance bill” you for the difference between what the provider charges and the total amount collected by the provider, which include payments from the Plan and copayments, coinsurance, or deductible amounts paid by you.

*Out-of-Network Air Ambulance Providers*

Covered **Air Ambulance Services** are treated as in-network for determining all cost-sharing amounts, including the coinsurance, copayments, deductible, and the out-of-pocket maximum. This means you will be responsible for the network cost-share amount and the Plan will count any cost-sharing payments incurred for covered **Air Ambulance Services** toward the in-network deductible and/or the in-network out-of-pocket maximums in the same manner it would count cost-sharing payments made for in-network services.

Your cost-sharing will be based on the lesser of the amount billed by the provider or facility or the **Qualifying Payment Amount**.

If you receive **Air Ambulance Services** from an out-of-network provider, the provider is not permitted to “balance bill” you for the difference between what the provider charges and the total amount collected by the provider, including payments from the Plan and copayments, coinsurance, or deductible amounts paid by you.

*Waiving Surprise Medical Bill Protections*

In certain limited circumstances, you can waive the balance billing and cost-sharing protections provided under the No Surprises Act. You may be able to waive these protections for (1) services from an Out-of-Network Provider with respect to a visit at a Network Facility or (2) services from an **Out-of-Network Emergency Facility** or provider after you are stabilized. This can occur if you are notified by the Out-of-Network Provider that the provider does not participate with the Plan and you provide informed consent to be treated by the provider and waive the protections.

If you give informed consent to be treated by the Out-of-Network provider, then the Plan will treat these services as Out-of-Network. This means you will be subject to Out-of-Network cost-sharing, the provider can bill you for the balance directly, and the provider can balance bill you for the difference between what the provider charges and the amount paid by the Plan and the cost-sharing amounts paid by you.

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You may not waive No Surprises Act protections for ancillary services provided by an Out-of-Network Provider in a Network facility. Ancillary services include items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology; items and services provided by assistant surgeons, hospitalists, and intensivists; and diagnostic services, including radiology and laboratory services.

## *Plan Payment to Provider*

The Plan will pay the provider or facility the **Out-of-Network Rate** minus any cost-sharing amounts (copayments, coinsurance, and/or amounts paid towards deductible) you paid.

## *Continuing Care*

If you are receiving care from a network provider that becomes out-of-network, you may have certain rights to continue your course of treatment if you are a “continuing care patient.”

A continuing care patient is a patient that

- is undergoing a course of treatment for a serious and complex condition from the provider or facility;
- is undergoing a course of institutional or inpatient care from the provider or facility;
- is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- is or was determined to be terminally ill (as determined under Social Security Act) and is receiving treatment for such illness from such provider or facility.

A serious and complex condition means a condition that

- in the case of an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
- in the case of a chronic illness or condition, a condition that
  - is life-threatening, degenerative, potentially disabling, or congenital; and
  - requires specialized medical care over a prolonged period of time.

If the Plan terminates its contract with your Network provider or facility or your benefits are terminated because of a change in terms of the providers' and/or facilities' participation in the Plan, you will be notified of the change and informed of your right to elect to receive transitional care from the provider. You may choose to continue your course of treatment under the same terms and conditions as would have applied for an in-network provider for up to 90 days after the notice is provided or until you no longer qualify as a continuing care patient (whichever is earlier). These providers cannot balance bill you during this time.

Termination of a contract includes the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

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*Provider Directory*

If you rely on information in the Plan's provider directory that inaccurately states that an out-of-network provider is in-network, you will only be subject to in-network cost sharing amounts. These cost-sharing amounts will be applied toward the in-network deductible and/or in-network out-of-pocket maximum in the same manner in-network cost-share would be applied.

*External Review*

In certain circumstances, you have a right to appeal and request an external review of a claim that was denied by the Plan. This external review will be available to dispute determinations that involve whether the Plan complied with the surprise billing and cost-sharing protections under the No Surprises Act.

*Definitions*

**Air Ambulance Service** means medical transport by helicopter or airplane for patients.

**Emergency Medical Condition** means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

**Emergency Services**, with respect to an **Emergency Medical Condition**, means:

- An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an **Independent Freestanding Emergency Department**, including ancillary services routinely available to the emergency department to evaluate such **Emergency Medical Condition**
- Such further medical examination and treatment to stabilize the patient within the capabilities of the staff and facilities available at the hospital or the **Independent Freestanding Emergency Department**
- Further services that are furnished by an out-of-network provider or **Out-of-Network Emergency Facility** after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay (regardless of the department of the hospital in which such further examination or treatment is furnished).

**Independent Freestanding Emergency Department** means a health care facility that (i) is geographically separate and distinct and licensed separately from a hospital under applicable State law; and (ii) provides any **Emergency Services**

**Out-of-Network Emergency Facility** means an emergency department of a hospital, or an **Independent**

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**Freestanding Emergency Department** (or a hospital, with respect to **Emergency Services** as defined), that does not have a contractual relationship directly or indirectly with the Plan, with respect to the furnishing of an item or service.

**Out-of-Network Rate** will be determined in the following order:

- the amount that the state approves under an All-Payer Model Agreement, if applicable
- the amount determined by a state law, if applicable;
- the payment amount agreed to by the Plan and provider or facility, if applicable;
- the amount approved under the independent dispute resolution (IDR) process.

**Qualifying Payment Amount (QPA)** generally means the median amount the Plan has contractually agreed to pay network providers or facilities for a particular covered service. This amount is updated annually to account for inflation.

**Recognized Amount**, for items and services furnished by an Out-of-Network provider or **Out-of-Network Emergency Facility**, the Recognized Amount will be determined in the following order:

- An amount determined by an All-Payer Model Agreement, if applicable
- An amount determined by a specified state law, if applicable;
- The lesser of the amount billed by the provider or facility or the **Qualifying Payment Amount (QPA)**

Sincerely,  
The Board of Trustees  
Sheet Metal Workers Local 7 Zone 3 Health  
and Welfare Plan