SUMMARY OF MATERIAL MODIFICATION TO THE SHEET METAL WORKERS LOCAL NO. 46 HEALTH FUND

Important Information Regarding Your Health Fund Benefits

This notice contains important information concerning benefits provided by the Sheet Metal Workers Local No. 46 Health Fund. Please attach this letter to your Summary Plan Description (SPD). It should be read and retained with your SPD for future reference.

Date: **October 31, 2016**

To: **All Active Participants, Retirees and COBRA Beneficiaries**

From: **The Board of Trustees**

INTRODUCTION

The Board of Trustees is proud of the valuable benefits provided to you and your families through the Sheet Metal Workers Local No. 46 Health Fund (the Plan). As Trustees to the Plan, we continually monitor the financial stability of the Plan to ensure that the Plan will continue to provide these important benefits well into the future. In order to maintain the high level of benefits provided by the Plan, revisions to our plan of benefits are necessary from time to time.

This notice describes important changes to the Sheet Metal Workers Local No. 46 Health Fund that are effective as of January 1, 2017.

SCHEDULE OF BENEFITS EFFECTIVE ON OR AFTER JANUARY 1, 2017

Below is a Schedule of the new benefit design which reflects the changes that will be made to the Plan effective as of January 1, 2017. The Schedule of Benefits contained in the current SPD is deleted and replaced in its entirety with the following Schedule of Benefits:

For Active Participants And Dependents		
Medical Benefits	**Coverage**	
Lifetime Maximum	Unlimited per person	
	Network/Participating Provider	Non-Network/Non Participating Provider
Calendar Year Deductible	$200 per person; $500 per family	$1000 per person; $3,000 per family
Calendar Year Out-Of-Pocket Maximum (does not include the annual deductible)	$3,000 Individual; $5000 Family for Medical: $3,000 Individual; $5,000 Family for Prescription Drugs	Not Applicable

***Medical Benefits that Require Pre-authorization**		
*Behavioral Health (inpatient facility and/or inpatient hospital) *Durable Medical Equipment (DME) *Home Care by an Agency *Hospice Facility *Hospice Home *Hospice Inpatient *Inpatient Acute Care Hospital *IV Therapy Home, Hospital and/or Office *MRI, MRA, PET, CAT any place of service *Private Duty Nursing (facility, home or as an inpatient in a hospital) *Rehabilitation Inpatient Facility *Substance Abuse (inpatient facility and/or inpatient hospital) *Substance Abuse Detoxification *Skilled Nursing Inpatient Facility	In this Schedule of Benefits, wherever a Specific Benefit begins with the asterisk (*), it will require that your provider seek preauthorization. For limitations of the specific benefit, see the chart below.	
Specific Benefits	**Network/Participating Provider**	**Non-Network/Non-Participating Provider**
Coinsurance (unless otherwise noted)	You pay 20%	You pay 70%
Allergy	**Network/Participating Provider**	**Non-Network/Non-Participating Provider**
Allergy Injection and Serum	No deductible, you pay $20 co-payment	After deductible, you pay 70%
Allergy Testing	No deductible, you pay $20 co-payment	After deductible, you pay 70%
Ambulance	**Network/Participating Provider**	**Non-Network/Non-Participating Provider**
Ambulance (includes medically necessary inter-health facility transfer)	No deductible, you pay $100 co-payment	No deductible, you pay $100 co-payment
Air Ambulance	After deductible, you pay 20%	After deductible, you pay 30%
Anesthesia	**Network/Participating Provider**	**Non-Network/Non-Participating Provider**
Inpatient Anesthesia	After deductible, you pay 20%	After deductible, you pay 30%
Outpatient Anesthesia	After deductible, you pay 20%	After deductible, you pay 30%
Office Anesthesia	After deductible, you pay 20%	After deductible, you pay 30%
Chiropractic Services	**Network/Participating Provider**	**Non-Network/Non-Participating Provider**
Chiropractic Services*	No deductible, you pay $35 co-payment	After deductible, you pay 70%

Manipulation by an Osteopath	No deductible, you pay $35 co-payment	After deductible, you pay 70%
*Chiropractic services and manipulation by an Osteopath benefits are covered for individuals 15 years of age and over. These benefits have $1,500 limit per year.		
Family Planning	**Network/Participating Provider**	**Non-Network/Non-Participating Provider**
Maternity Prenatal & Postnatal Office Visits	No deductible, you pay $20 co-payment for first visit	After deductible, you pay 70%
Coverage is limited to the Active Participant or their Spouse. This benefit is not covered for dependent child(ren) of the Active Participant.		
Maternity Hospital Charges for Mother Physician Charges For Mother while in the hospital	After deductible, you pay 20%	After deductible, you pay 70%
Family Planning	No deductible, you pay $35 co-payment	After deductible, you pay 70%
Infertility Treatment	Not covered	Not covered
Reversal of Sterilization	Not covered	Not Covered
Elective Abortion	After deductible, you pay 20%	After deductible, you pay 70%
Benefits under Family Planning are limited to the Active Participant or their Spouse. This benefit is not covered for dependent child(ren) of the Active Participant.		
Home Health Care	**Network/Participating Provider**	**Non-Network/Non-Participating Provider**
*Home Care by an Agency/ Private Duty Nursing	After a $50 deductible, you pay 20%	After a $50 deductible, you pay 70%
	The $50 deductible is a separate deductible specific for the home health care benefit that is not included in the Calendar Year Deductible. The home health care benefit has a maximum benefit of 40 visits.	
Hospice	**Network/Participating Provider**	**Non-Network/Non-Participating Provider**
*Hospice Facility	No deductible, you pay 20%	Not Covered
*Hospice Home	No deductible, you pay 20%	Not Covered
*Hospice Inpatient	No deductible, you pay 20%	Not Covered
Bereavement Counseling	No deductible, you pay 20% Limit of 5 days	Not Covered
Hospitalization	**Network/Participating Provider**	**Non-Network/Non-Participating Provider**
In-Patient	After deductible you pay 20%	After deductible you pay 70%
Out-Patient	After deductible you pay 20%	After deductible you pay 70%
Inpatient Services	**Network/Participating Provider**	**Non-Network/Non-Participating Provider**
Inpatient Consultation	After deductible, you pay 20%	After deductible, you pay 70%
Inpatient Newborn Physician Visit	No deductible, covered in full	After deductible, you pay 70%
*Inpatient Acute Care Hospital	After deductible, you pay 20%	After deductible, you pay 70%
Inpatient Physician Visit	After deductible, you pay 20%	After deductible, you pay 70%
Inpatient Nursery	No deductible, you pay 20%	After deductible, you pay 70%
Diagnostic Services	**Network/Participating Provider**	**Non-Network/Non-Participating Provider**
Diagnostic Testing	After deductible, you pay 20%	After deductible, you pay 70%
	MRI, MRA, PET, CAT require pre-authorization at any place of service.	
Diagnostic Lab Services	After deductible, you pay 20%	After deductible, you pay 70%
Diagnostic X-Ray Services	After deductible, you pay 20%	After deductible, you pay 70%

Durable Medical Equipment (DME)	Network/Participating Provider	Non-Network/Non-Participating Provider
*Durable Medical Equipment (DME)	After deductible, you pay 20%	Not covered
	* DME requires pre-authorization	
Medical/Surgical supply	After deductible, you pay 20%	Not covered
Ostomy Supplies	After deductible, you pay 20%	Not covered
Foot Orthotics	After deductible, you pay 20%	Not covered
Orthopedic Shoe and appliance	After deductible, you pay 20%	Not covered
Prosthetic external brace, splint, and non-dental prosthetic appliances such as artificial limbs, larynx and eyes. Dental prostheses replacing accidentally injured natural teeth within 12 months of accident.	After deductible, you pay 20%	Not covered
Prosthetic to replace functioning body part	After deductible, you pay 20%	Not covered
Oxygen and supplies	After deductible, you pay 20%	Not covered
Diabetic Supply	After deductible, you pay 20%	Not covered
	Diabetic supply benefit only covers supplies not covered by the pharmacy benefit.	
Physician Services	**Network/Participating Provider**	**Non-Network/Non-Participating Provider**
Primary Care Physician Visit– (PCP)	No deductible, you pay $20 co-payment	After deductible, you pay 70%
Specialist office visit	No deductible, you pay $35 co-payment	After deductible, you pay 70%
Urgent Care Facility	No deductible, you pay $25 co-pay	No deductible, you pay $75 co-payment
Telemedicine	No deductible, you pay $10 co-payment	Not covered
	Please visit www.excellusbcbs.com/telemedicine for 24/7/365 on-demand access to U.S. board certified doctors, or call the number on the back of your card for further information.	
Educational Services	**Network/Participating Provider**	**Non-Network/Non-Participating Provider**
Diabetic Education	No deductible, you pay $20 co-payment	Not covered
Nutritional Counseling	No deductible, you pay $20 co-payment	Not covered
Educational Services required under the Affordable Care Act are covered in full with no deductible		
Surgical Services	**Network/Participating Provider**	**Non-Network/Non-Participating Provider**
Newborn Circumcision	No deductible, you pay 20%	After deductible, you pay 70%
Office Surgery Physician	No deductible, you pay $35 co-payment	After deductible, you pay 70%
Outpatient Surgery Physician charge	After deductible, you pay 20%	After deductible, you pay 70%
Free Standing Surgical facility	After deductible, you pay 20%	After deductible, you pay 70%
Inpatient Surgery Physician charge	After deductible, you pay 20%	After deductible, you pay 70%
Outpatient Assistant Surgeon (MD only)	After deductible, you pay 20%	After deductible, you pay 70%
Inpatient Assistant Surgeon (MD only)	After deductible, you pay 20%	After deductible, you pay 70%

Medical Oral Surgery	After deductible, you pay 20%	After deductible, you pay 70%
Emergency Services	**Network/Participating Provider**	**Non-Network/Non-Participating Provider**
ER Facility	No deductible, you pay $100 co-payment	No deductible, you pay $100 co-payment
Co-payment is waived if patient is admitted to the hospital		
Therapy Services	**Network/Participating Provider**	**Non-Network/Non-Participating Provider**
Occupational Therapy other place of service	After deductible, you pay 20%	After deductible, you pay 70%
Occupational Therapy Outpatient Hospital	After deductible, you pay 20%	After deductible, you pay 70%
Physical Therapy other place of service	After deductible, you pay 20%	After deductible, you pay 70%
Physical Therapy Outpatient Hospital	After deductible, you pay 20%	After deductible, you pay 70%
Respiratory Therapy Outpatient Hospital	After deductible, you pay 20%	After deductible, you pay 70%
Respiratory Therapy other place of service	After deductible, you pay 20%	After deductible, you pay 70%
Speech Therapy other place of service	After deductible, you pay 20%	After deductible, you pay 70%
Speech Therapy Outpatient Hospital	After deductible, you pay 20%	After deductible, you pay 70%
The above benefits under Therapy Services have a limit of 45 days combined therapy.		
*Rehabilitation Inpatient Facility	After deductible you pay 20%	After deductible, you pay 70%
	The Rehabilitation Inpatient Facility benefit has a limit of 60 days per calendar year.	
Cardiac Rehabilitation	**Network/Participating Provider**	**Non-Network/Non-Participating Provider**
Cardiac Rehabilitation Outpatient Hospital	After deductible, you pay 20%	After deductible, you pay 70%
Cardiac Rehabilitation other place of service	After deductible, you pay 20%	After deductible, you pay 70%
Chemotherapy	**Network/Participating Provider**	**Non-Network/Non-Participating Provider**
Chemotherapy Outpatient	After deductible, you pay 20%	After deductible, you pay 70%
Chemotherapy Office	After deductible, you pay 20%	After deductible, you pay 70%
Radiation Therapy	**Network/Participating Provider**	**Non-Network/Non-Participating Provider**
Radiation Therapy Office	After deductible, you pay 20%	After deductible, you pay 70%
Radiation Therapy OP	After deductible, you pay 20%	After deductible, you pay 70%
Dialysis	**Network/Participating Provider**	**Non-Network/Non-Participating Provider**
Dialysis Outpatient Hospital	After deductible, you pay 20%	Not covered
Dialysis other location	After deductible, you pay 20%	Not covered
IV Therapy	**Network/Participating Provider**	**Non-Network/Non-Participating Provider**
*IV Therapy Home, Hospital or Office	After deductible, you pay 20%	After deductible, you pay 70%
Preventive/Routine Services	**Network/Participating Provider**	**Non-Network/Non-Participating Provider**
Routine Exam Adult	No deductible, covered in full Limit one per year.	Not covered
Routine Adult Immunization	No deductible, covered in full	Not covered
Routine Exam Child	No deductible, covered in full covered up to age 21	Not covered

Routine Child Immunization	No deductible, covered in full	Not covered
Routine Mammogram	No deductible, covered in full	Not covered
HPV Vaccine	No deductible, covered in full	Not covered
Routine Gynecological Exam	No deductible, covered in full.	Not covered
Routine PAP Smear	No deductible, covered in full.	Not covered
Routine PSA test	No deductible, covered in full	Not covered
Routine Colonoscopy	After deductible, covered in full	Not covered
Other ACA Required Preventive Services	No deductible, covered in full for preventive services required under the ACA Preventive Benefits. See the description of *Preventive Benefits* under the Non-Grandfathered Provisions for more details about this benefit.	Not Covered
Behavioral Health	**Network/Participating Provider**	**Non-Network/Non-Participating Provider**
*Inpatient Facility (not a hospital)	After deductible, you pay 20%	After deductible, you pay 70%
*Inpatient Hospital	After deductible, you pay 20%	After deductible, you pay 70%
Inpatient Facility (not a hospital) Inpatient Physician Visit	After deductible, you pay 20%	After deductible, you pay 70%
Partial Hospitalization Program or Day Treatment	After deductible, you pay 20%	After deductible, you pay 70%
Outpatient/Office	No deductible; you pay $35 co-pay	After deductible, you pay 70%
Alcohol and Substance Abuse	**Network/Participating Provider**	**Out-of-Network**
*Substance Abuse treatment received at an Inpatient Facility (not a hospital)	After deductible, you pay 20%	After deductible, you pay 70%
*Substance Abuse treatment received in a hospital	After deductible, you pay 20%	After deductible, you pay 70%
Hospital Inpatient Physician Visit	After deductible, you pay 20%	After deductible, you pay 70%
*Detoxification	After deductible, you pay 20%	After deductible, you pay 70%
Outpatient/Office	No deductible; you pay $35 copay	After deductible, you pay 70%
Skilled Nursing	**Network/Participating Provider**	**Non-Network/Non-Participating Provider**
Physician Visit Skilled Nursing Facility	After deductible, you pay 20%	After deductible, you pay 70%
*Skilled Nursing Inpatient Facility	After deductible, you pay 20%	After deductible, you pay 70%
	Limit 45 days per year.	
Miscellaneous Services	**Network/Participating Provider**	**Non-Network/Non-Participating Provider**
Acupuncture	No deductible, you pay 50%	After deductible, you pay 50%
	Limit 10 visits per year.	
Blood and Blood Products	After deductible, you pay 20%	After deductible, you pay 70%
Pre admission Testing	No deductible, you pay 20%	After deductible, you pay 70%
Enteral Formula (including orally administered Neocate® formula)	No deductible, you pay 20%	No deductible, you pay 70%
	Must be medically necessary.	
Modified Food Product	No deductible, you pay 20%	No deductible, you pay 70%
	Must be medically necessary.	
Obesity Surgery	After deductible, you pay 20%	After deductible, you pay 70%

	Must be medically necessary.	
Prescription Drug Benefit	**Retail Pharmacy (30-days)**	**Mail Order Program (90-days)**
Generic Medications (Tier 1)	$5	$10
Formulary Medications (Tier 2)	$20	$30
Non-Formulary Medications (Tier 3)	$35	$45
Specialty Drugs (Tier 4)	$50	$50
Hearing Benefits	**Coverage (For Active Participants Only)**	
	Network/Participating Provider	**Non-Network/Non-Participating Provider**
Hearing Exam	No deductible, $25 co-payment	Not Covered
Hearing Aid Appliance Deductible	$25 per person	Not Covered
Hearing Aid Appliance Coinsurance	After hearing aid appliance deductible, Plan pays 80% of the reasonable and customary cost	Not Covered
Hearing Aid Appliance Maximum Benefit	Plan pays up to $1000 per person every five years	Not Covered
Vision Benefits	**Coverage (For Active Participants and Dependents Only)**	
Davis Vision	Continuation of Current Vision Benefits	
Dental Benefits	**Coverage (For Active Participants and Dependents Only)**	
Calendar Year Deductible	$50 Individual; $150 Family (does not apply to preventive benefits)	
Calendar Year Maximum	Plan pays up to $1,500 per person (age 14 and over). Plan pays unlimited amount for Pediatric Dental Benefits for children (birth to age 14). Orthodontic benefits remain subject to the $2,000 lifetime maximum.	
Orthodontic Deductible	$50 – Once per Lifetime	
Orthodontic Coinsurance	You pay 50%	
Orthodontic Lifetime Maximum	Plan pays up to $2,000 per child up to age 19 or per adult with TMJ	
Weekly Income Accident And Sickness Benefits	**Coverage (For Active Participants Only)**	
Weekly Benefit	$150 per week (subject to FICA tax)	
Maximum Benefit Period	Up to 39 weeks per each period of disability.	
Benefits Begin	Covered accident: First day you are unable to work Covered sickness: Eighth day you are unable to work	
Life Insurance Benefits	**Coverage (For Active Participants Only)**	
Benefit Amount	$50,000	
AD&D Insurance Benefits	**Coverage (For Active Participants Only)**	
Principal Benefit Amount	$50,000	

Mandatory Mail-Order for Maintenance Medications

Effective January 1, 2017, if you are taking a drug that is on the Plan's "maintenance" drug list, you must use the mail order program for refills. A one-time "grace" fill for a 30-day supply of

maintenance medication is available at a retail pharmacy. If you take maintenance drugs, in order for benefits to be payable beyond the first fill you must fill your prescriptions by mail – and not your local retail pharmacy.

Maintenance Medications are medications taken on a regular basis for chronic conditions such as high blood pressure, arthritis, and diabetes. EnvisionRx maintains the most up-to-date list of drugs subject to the mandatory mail-order program. To see if the medications that you require must be filled through the mail-order service and for further information on how to use the mail-order program, please contact EnvisionRx by calling the number on the back of your ID card.

Non-Grandfathered Provisions

Effective January 1, 2017, the Plan will no longer be considered a grandfathered plan under the Patient Protection and Affordable Care Act (the "Affordable Care Act" or "ACA"). As such, the Plan will implement the following changes to the Plan:

- ***Out-of-Pocket Maximum for In-Network Services.*** An out-of-pocket maximum is the most you could pay during a Plan year for your share of in-network costs of covered services before the Plan starts to pay 100% for in-network covered essential health benefits. The out-of-pocket maximum beginning January 1, 2017 will be $3,000 for an individual and $5,000 for a family. This maximum will apply to the cost-sharing for covered "essential health benefits" received from in-network providers for medical benefits and will include all copayments, deductibles and coinsurance.

  A separate out-of-pocket maximum of $3,000 for an individual and $5,000 for a family will apply for pharmacy benefits effective January 1, 2017. This means that no Prescription Drug Benefit expenses will accumulate toward the medical out-of-pocket maximum (and vice versa). This maximum will apply to the cost-sharing for covered Prescription Drug Benefits received from in-network pharmacies and will include all copayments, deductibles and coinsurance.

  Expenses for services the Plan does not cover, expenses that are not considered to be essential health benefits, expenses for dental and optical benefits, and balance billing will not count toward the out-of-pocket maximums.

  Out-of-Network Services: The out-of-pocket maximum for out-of-network benefits will be eliminated.

- ***Preventive Services.*** The preventive services to which this new rule applies are those that are required under the Affordable Care Act. The Plan will pay 100% of the costs incurred for certain preventive services when those services are provided by a participating **in-network provider.** This means that these services will not be subject to any cost sharing (in other words, you will not have to pay a copayment for these services).

  The required services include services that are highly recommended by the U.S. Preventive Services Task Force (USPSTF) (have an "A" or "B" rating), the Health Resources and Services Administration (HRSA) that is part of HHS, the Centers for Disease Control and Prevention (CDC) (for required immunizations), and the Bright

Futures initiative for children funded by HRSA and developed by the American Academy of Pediatrics. Guidelines issued by HRSA include a set of required preventive services for women (such as the full range of FDA-approved contraceptives). For example, the Plan will cover:

- Certain preventive services for adults that cover a set of preventive services like screening tests at specified intervals based on a person's age and sex.
- Certain preventive health services for women like breast cancer screenings every 1-2 years for women age 40 and older.
- Certain preventive services for newborns, infants and children to age 21, for example, well baby and well child visits at specified intervals.
- Immunizations for infants, children, adolescents and adults as recommended by the federal Centers for Disease Control and Prevention Advisory Committee on Immunization Practice (ACIP).
    - Certain preventive prescriptions, including FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate). Most preventive prescriptions will be covered under the Prescription Drug Plan but a few may be covered under the Medical Plan. For preventive prescriptions to be covered, it must be prescribed by a doctor and meet the criteria set out by EnvisionRx. If a covered item or drug is available over-the-counter and is covered under this provision, you must present a prescription at the time of purchase in order for it to be covered under the Plan.

To find out if a particular preventive service will be paid at 100% when provided by a participating in-network provider, contact Excellus BlueCross BlueShield by calling the number on the back of your ID card. To find out if a particular preventive service will be paid at 100% when provided by a participating pharmacy, contact EnvisionRx by calling the number on your ID card.

- ***Designation of Primary Care Provider.*** Under the Plan, there is no requirement to designate a primary care provider. However, should you wish to choose a primary care provider, you have the right to designate any primary care provider who participates in the Plan's Network and who is available to accept you or your family members. This includes the right to designate a participating pediatrician as your child's primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Excellus BlueCross BlueShield.

- ***Direct Access to Obstetrical and Gynecological Care.*** You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Excellus BlueCross BlueShield.

- **Clinical Trials.** The Plan will cover routine patient costs for items and services furnished in connection with participation in an approved clinical trial for cancer and other life-threatening conditions if the Plan would provide those items and services to patients not participating in a trial.

  If you are eligible to participate in an Approved Clinical Trial with respect to treatment of cancer or another life-threatening disease or condition, the Plan will:

  - Not deny you participation in the trial;
  - Not deny, limit or impose additional conditions on the Plan's coverage of routine patient costs for items, services or drugs otherwise covered by the Plan that are furnished in connection with participation in the trial; and
  - Will not discriminate against you because of your participation in the trial.

  The Plan will deem you eligible to participate in the trial if:

  i) Your health care provider is a participating provider in the Plan and that provider has concluded that your participation in the trial would be medically appropriate; or
  ii) You provide medical and scientific information establishing that your participation would be medically appropriate.

  Routine patient costs do not include the following:

  - The investigational item, device, or service, itself;
  - Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
  - A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

  If one or more of the Plan's participating providers is participating in a clinical trial, the Plan may require that you participate in the trial through such a participating provider if the provider will accept you as a participant in the trial.

  An Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and that is funded or approved by the federal government, conducted under an investigational new drug application reviewed by the federal Food and Drug Administration, or a drug trial exempt from having such an investigational new drug application.

  A life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

- **Emergency Room Visits.** The Plan covers emergency services provided in hospital emergency rooms when you are suffering from an emergency medical condition (as defined below). You do not have to obtain prior authorization from the Plan before seeking emergency services in a hospital emergency room. The $100 copayment for an

emergency room visit applies to both in-network and out-of-network facilities. The copayment is waived if admitted.

- Emergency services (for patients with an emergency medical condition) are defined to include a medical screening examination and treatment to stabilize the patient.
- An emergency medical condition is one 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 various types of serious harm (specifically, placing the health of the person (with respect to a pregnant woman, the woman or the fetus) in serious jeopardy, serious impairment to bodily functions, and serious dysfunction of any bodily organ or part).

- **Provider Non-Discrimination.** The Plan will not discriminate with respect to participation under the Plan or coverage against any health care provider who is acting within the scope of his or her license or certification under applicable state law. To the extent required by Health Reform regulations, a physician or provider as defined by the Plan now includes a health care provider acting within the scope of his or her license or certification under applicable State laws who is performing a covered service under this Plan.

- **Internal and External Review of Coverage Determinations.** As you know, the Plan provides an extensive internal appeals procedure that allows you and your family the opportunity to request review of claims determinations that you think are not correct. Under the new Affordable Care Act rules, if your internal appeal is denied, you will have the right to appeal to an independent reviewer (External Review procedures).

CLAIMS AND APPEALS PROCEDURES

The updated Claims and Appeals procedures will be distributed to you by January 1, 2017. In addition, the Fund is in the process of updating the Summary Plan Description and you will receive more information about these changes in the upcoming year.

Questions?
For more information, please contact the Fund at 244 Paul Rd., Rochester, NY 14624 or by telephone at 585-458-0400.

Plan Sponsor: Sheet Metal Workers Local No. 46 Health Fund
Sponsor's EIN: 16-0760551
Plan Number: 501
Plan Year: July 1st to June 30th

You should keep this Notice together with your Summary Plan Description at all times. The two documents should be read together for an accurate depiction of your current health plan benefits. If you have any questions, contact the Fund Office.

The Board of Trustees or its duly authorized designee, reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan, or any benefits provided under the Plan, in whole or in

part, at any time and for any reason, in accordance with the applicable amendment procedures established under the Plan and the Agreement and Declaration of Trust establishing the Plan (the "Trust Agreement").

No individual other than the Board of Trustees (or its duly authorized designee) has any authority to interpret the plan documents, make any promises to you about benefits under the Plan, or to change any provision of the Plan. Only the Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the terms of the Plan and decide all matters arising under the Plan.