

SHEET METAL #10 BENEFIT FUND
SUMMARY PLAN DESCRIPTION/PLAN DOCUMENT
FOR RETIRED PARTICIPANTS

May 2018

**Sheet Metal #10 Benefit Fund
Summary Plan Description
For Retired Participants**

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May 2018

To All Retired Eligible Participants:

We are pleased to provide you with this revised and updated 2018 Summary Plan Description for Retired Eligible Participants (Retiree SPD). We are proud of the benefits package that we are able to provide to you and your family.

This SPD describes the eligibility requirements for coverage and benefits provided through the Sheet Metal #10 Benefit Fund for Retired Participants as of May 1, 2018. There have been many changes to the Plan since this document was last printed, so please read your SPD carefully and share it with your family. While you have been notified of many of these changes, there are some recent updates to be aware of that we've incorporated into this new SPD:

- *Hearing Aids*, page 4, the Plan now provides for one examination per calendar year, whereas previously the Plan covered the exam every two years with a \$150 limit.
- *Orthotics*, page 5, the Plan removed the \$300 limit on orthotics benefits.
- *TMJ*, page 6, the Plan removed the \$600 lifetime maximum benefit for appliances.
- *Specialty Drugs*, page 39, effective March 1, 2018, the Plan is adding a coupon copayment program for certain specialty drugs as further detailed in the SPD's Prescription Drug Benefit.
- *Compound Drugs*, page 40, the Plan no longer covers compound drugs that contain bulk chemicals that are not FDA approved. Compound kits and pain patches are also excluded.

As the above noted changes indicate, there is important information in the SPD that you must be aware of. The following sections can help you better understand the Plan and the benefits it provides:

- *Schedule of Benefits* (page 3), which is a summary of the benefits available to you under the Plan;
- *Important Contact Information* (page 8), which provides contact information for the various benefits provided by your plan;
- *Eligibility* (page 17), which describes when you become eligible for benefits and when you lose eligibility; and
- *Life Events* (page 28), which explains what happens to your benefits and what you may need to do when certain life events happen.

In addition to these sections, throughout this SPD, there are boxes of highlights covering important points and tips on how to get the most out of your benefits. We hope you find this format easy to use and helpful.

Please note that if you are eligible for Medicare, then your benefits under this Plan are coordinated with Medicare as primary, SMW+ (Medicare wraparound) as secondary and this Fund as third.

If you have any questions, contact Wilson-McShane Corporation as Claims Administrator or the Fund Office. The success of the Plan is due to the cooperation received from the Union, SMARCA, and Eligible Employees. We are grateful for your cooperation.

Sincerely yours,
Board of Trustees

The Trustees reserve the right to amend, modify, or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant. Participants will be notified of any Plan changes in writing.

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INTRODUCTION

This booklet is designed to help you understand the benefits available to you. We urge you to read the booklet and share it with your family. In addition, we recommend that you keep this booklet with your important papers so you can refer to it when needed.

About This Booklet

We've organized the SPD in a way that will be useful to you. This booklet includes:

- A summary of benefits;
- A listing of important contact information;
- Information about when you and your Dependents can participate in the Plan;
- An explanation of your coverage under the Plan;
- Information about how to file claims and appeals;
- General Plan administrative information; and
- A glossary of important definitions.

Your Responsibility

It is important to remember that the Plan is not designed to cover every health care expense. The Plan pays charges for eligible expenses, up to the limits and under the conditions established by the Plan rules. The decisions about how and when you receive medical care are up to you and your doctor – not the Plan. The Plan determines how much it will pay. You and your doctor must decide what medical care is best for you.

This booklet has been prepared for eligible retirees in the Sheet Metal #10 Benefit Fund and describes the benefits in effect as of May 1, 2018. This edition replaces and supersedes any previous Summary Plan Description. The Trustees reserve the right and have the authority to amend, modify, eliminate benefits, or terminate the Plan at any time. In addition, the Trustees, or such other persons as delegated by the Trustees, have the discretion to interpret and construe the rules of the Plan and the terms of this booklet.

INTRODUCTION

Grandfathered Status

The Sheet Metal #10 Benefit Fund believes its Plan of benefits is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Sheet Metal #10 Benefit Fund may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventative health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at Sheet Metal #10 Benefit Fund, Attn: Plan Administrator, 1681 East Cope Avenue, Suite B, Maplewood, MN 55109-2631; 651-770-0991. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

**SCHEDULE OF BENEFITS IF YOU RETIRED ON OR
AFTER NOVEMBER 1, 1977**

(IF YOU RETIRED BEFORE JANUARY 1, 1977, THEN USE THE SCHEDULE OF BENEFITS ON THE APPENDIX AT THE BACK OF THIS DOCUMENT.)

Eligible Retirees and Dependents	
Major Medical Expense Benefit	Coverage
Annual Deductible Before the Plan pays for most covered expenses, you pay	\$135 per person each year; \$405 family maximum
Coinsurance	80%, up to the annual out-of-pocket maximum
Annual Out-Of-Pocket Maximum Plan pays 100% of covered charges for the remainder of the year, once you reach your Out-Of-Pocket Maximum: Individual Out-Of-Pocket Maximum Family Out-Of-Pocket Maximum Annual Out-Of-Pocket Maximum does not include your deductible	\$1,080 per person; \$3,240 per family
Doctor on Demand Medical video visits Mental health video visits (Not all video visits are covered, only those through Doctor on Demand).	100% \$50 copayment
Immunizations (see next row for immunizations administered at a Pharmacy)	100% of Reasonable and Customary after deductible
Office visits and testing at PPO Retail Health Clinic (such as Minute Clinic and Immunizations administered at a Pharmacy)	100% of Reasonable and Customary, no deductible
Emergency Room Services	\$50 copayment, waived if you are admitted to hospital
InPatient In-Network Hospital Coverage	80% after annual deductible
InPatient Out-of-Network Hospital Coverage	No coverage

SCHEDULE OF BENEFITS

Eligible Retirees and Dependents	
Major Medical Expense Benefit	Coverage
Mental/Behavioral and Substance Abuse Disorder – In-Network Inpatient Service	80% after annual deductible
Mental/Behavioral and Substance Abuse Disorder – Out-of-Network Inpatient Service	No coverage
Mental/Behavioral and Substance Abuse Disorder – In-Network Outpatient Service	80% after annual deductible
Mental/Behavioral and Substance Abuse Disorder – Out-Network Outpatient Service	80% after annual deductible
Bariatric Surgery Must be performed at a Blue Center of Distinction. (see page 35 for details and page 47 for an exclusion from coverage if requirements are not met)	\$20,000 lifetime maximum
Chiropractic Treatment	80% after annual deductible up to a maximum of \$30 per visit
Diagnostic Imaging and Radiology * If imaging or radiology services are obtained at a Centers for Diagnostic Imaging (CDI) facility, then charges will be paid at 100% after the annual deductible	80% after annual deductible*
Elective Sterilization Plan Coinsurance	80% of Reasonable and Customary
Health Education Plan Coinsurance Lifetime Maximum	80% of Reasonable and Customary \$6,000 per person
Hearing Care Plan Coinsurance (including one hearing examination per calendar year) Maximum Benefit for: Two hearing aid instruments per five consecutive calendar years *Maximum benefit does not apply to individuals under age 19 (coinsurance does apply).	80% of Reasonable and Customary \$1,000 (per hearing aid)

SCHEDULE OF BENEFITS

Eligible Retirees and Dependents	
Major Medical Expense Benefit	Coverage
Home Health Care Maximum days per calendar year	120 days
Hospice Care Lifetime Maximum	185 days per person
Lodging Benefit	\$30/night; 90-day maximum
Orthotics	80% of Reasonable and Customary up to the first \$300 and then 50% of all remaining costs
Physical Therapy	80% after annual deductible
Preventive Care (including one routine annual exam and cancer exam per year)	80% after annual deductible
Skilled Nursing Care Daily Room and Board Confinement Maximum	100% of Reasonable and Customary 90 days; must have at least 60 days in between related confinements
Smoking Cessation: (see page 42) Nicotine Replacement Therapy Aids Oral Prescription Medications	100% reimbursement 80% name brand; 90% generic
Speech & Occupational Therapy Lifetime Visit Limit	80% after annual deductible up to a maximum of 35 visits
Additional Speech Therapy Benefit for the treatment of <ul style="list-style-type: none"> • Brain injuries resulting from trauma or a medical and/or substance use condition or disorder, whether congenital or acquired in origin; • Neurological disorders, whether congenital or acquired in origin; and • Physical impairment, whether congenital or acquired in origin. 	80% after annual deductible
Spinal Care for Back and Neck * Individuals who meet the eligibility requirements of Physician's Neck and Back Center and who participate in its neck and back Rehabilitation Program will have charges paid at 100% after the annual deductible.	80% after annual deductible*

SCHEDULE OF BENEFITS

Eligible Retirees and Dependents	
Major Medical Expense Benefit	Coverage
Temporomandibular Joint Disorder (TMJ or TMD)	80% of Reasonable and Customary up to the first \$600 and then 50% of all remaining TMJ benefits.
Wigs for Hair Loss Due to Chemotherapy or Illness	One wig up to \$500 (lifetime maximum)
Pharmacy Benefit	
Prescription Drugs	Not subject to an annual deductible or out-of-pocket maximum
Retail Prescription Drug Card Program Available at network retail pharmacies and the mail service pharmacy when you show your Sheet Metal #10 Benefit Fund identification card	Plan pays 90% for generic prescription drugs, and 80% for brand name prescription drugs
Out-of-Network Retail Pharmacy	Plan reimburses 80%
If another drug plan is primary or paid by the Veterans Administration	100% of copayment, requires no deductible
Mail Service If Plan coverage is primary for you	Plan pays 90% for generic prescription drugs, and 80% for brand name prescription drugs
Over-the-Counter Medications Certain over-the-counter drugs such as proton pump inhibitors and non-sedating antihistamines, subject to a 34-day supply	Plan pays 90%

Pharmacy Benefit	
<p>Specialty Drug Program Specialty drugs are typically medications that require close supervision and monitoring of the patient's therapy; need frequent dosage adjustments; need special storage, handling, and administration; and are significantly more costly than traditional drugs</p> <p>If you use the Specialty Drug Program</p> <p>If you do not use the Specialty Drug Program</p>	<p>Plan pays 100%</p> <p>Not covered</p>
<p>90-Day Retail Program Available for participants taking long-term maintenance medications; offers discount pricing and no dispensing fees when maintenance medications ordered on a three-month supply basis at certain retail pharmacies</p>	<p>Plan pays 90% for generic prescription drugs, and 80% for brand name prescription drugs</p>
<p>Step Therapy Program Certain prescription drugs will be subject to a step therapy program. This program uses a step approach to provide coverage for the clinically appropriate, more cost-effective medication, and then progresses to other more costly therapy(s) if the initial medication does not provide the adequate therapeutic benefit</p>	<p>Plan pays 90% for generic prescription drugs, and 80% for brand name prescription drugs</p>
Dental Expense Benefit	
<p>Dental (For Participants who elect this benefit and pay the required premium)</p>	<p>Benefits Payable Under Optional Separate Dental Policy</p>
Vision Expense Benefit	
<p>Vision</p>	<p>Card provides discount at some Retail outlets. But there is no other Benefit including reimbursement and no pediatric benefit or reimbursement</p>

IMPORTANT CONTACT INFORMATION

The chart that follows shows the contact information for the various organizations that provide services under the Sheet Metal #10 Benefit Fund.

If you have a question or need information about	Contact	Phone numbers	Website
Eligibility, ID cards, Medical and Dental claims and benefits questions.	Wilson-McShane Corporation 3001 Metro Drive, #500 Bloomington, MN 55425	800-535-6373 952-854-0795	N/A
To find a preferred provider: Medical	Blue Cross Blue Shield MN	Use website	www.bluecrossmnonline.com
View claims information, find providers and order ID cards	Blue Cross Blue Shield MN	Use website	www.bluecrossmnonline.com
Prescription Drug	Prime Therapeutics	800-509-0545	www.myprime.com
Diagnostic Imagine	Centers for Diagnostic Imaging	866-765-7138	www.cd radiology.com
Neck and Back Clinics	Physicians Neck & Back Clinics	651-735-2225	www.pnbconline.com
Hearing Benefits	EPIC Hearing Healthcare	866-956-5400	www.epichearing.com
Employee Assistance Plan	TEAM	800-634-7710 651-642-0182	www.team-mn.com
Tobacco Cessation Support Program	Blue Cross Blue Shield MN	888-662 BLUE (2583)	www.bluecrossmn.com
Doctor on Demand	Online medical service through Blue Cross Blue Shield of MN	N/A	www.doctorondemand.com/bluecrossmn
Maternity Management Support	A service of Blue Cross Blue Shield of MN	866-489-6948	www.bluecrossmn.com
Address changes, beneficiary forms	Fund Office	651-770-0991	www.smw10.org

IMPORTANT NOTICES

When reading this document, it is important for you to know:

- When the term “you” is used, it means you and/or your eligible Dependents.
- The Board of Trustees reserves the right to interpret, amend, or terminate any and all provisions of the Plan.
- It is important that you notify the Fund Office whenever you:
 - Change your home/ mailing address;
 - Enter and return from the uniformed services of the United States;
 - Divorce;
 - Have a Dependent who no longer meets the Plan’s definition of a Dependent to ensure that he or she receives proper COBRA notice; and
- The Plan reserves the right to change or discontinue any PPO anytime.
- The Plan may receive rebates from Prime Therapeutics for prescriptions purchased under the Plan. These rebates will be used to reduce the Plan’s expenses.

The Trustees reserve the right to amend, modify, or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant. Participants will be notified of any Plan changes in writing.

DEFINITIONS

The following are definitions of certain terms used in this SPD and are important to your understanding of your coverage. Refer to these definitions as you read this SPD to get a COMPLETE explanation of your benefit program.

Accidental Injury: Any unforeseen or unintended trauma to the body, excluding over-utilization of a body part.

Age 65: The age attained at 12:01 a.m. On the first day of the month in which your 65th birthday occurs.

Ambulatory Medical-Surgical Facility: A freestanding ambulatory surgical center or a facility offering ambulatory medical services, provided such facilities have been reviewed and approved by the appropriate state agency.

Calendar Year: The period of 12 months starting on January 1st of each year and ending on December 31st in the same calendar year.

Caregiver: A person - not associated with a hospice agency - who resides in the home and provides non-medical services and companionship. This may be a family member.

Claims Administrator or Third-Party Administrator: The Third-Party Administrator hired by the Board of Trustees to process claims and provide other administrative functions for the Fund.

Consultation: A review of the medical history, a review of laboratory and x-ray examinations, an examination of you, and a report written by the consulting Physician if requested by the attending Physician.

Consultation Service: Consultations by a Physician called in by the Physician providing medical treatment to you while confined as a patient in the Hospital as a result of a Non-Occupational Injury or Disease, or as a result of a pregnancy for which benefits are payable.

Cosmetic Surgery: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Examples are removal of tattoos and breast augmentation.

Dependent: A Dependent includes any of the following persons who are eligible for coverage under this Plan as a covered Dependent (if enrolled in the Plan), provided they are not also an eligible covered employee: (Note a Dependent cannot be added after you become eligible for Retiree Plan coverage)

1. The eligible employee's lawful spouse or surviving spouse from whom the eligible employee is not divorced or legally separated.
2. Each child who has not yet reached age 26 (through the end of the month in which they turn 26), including:
 - a. A natural child, a lawfully adopted child, or a child placed for adoption (unless placement is disrupted prior to legal adoption and the child is removed from placement).
 - b. Either of the following in a parent-child relationship with the eligible employee:
 - i. A stepchild only for the duration of the marriage of the eligible employee and the stepchild's parent;

DEFINITIONS

- ii A child who is named as an alternate payee in a Qualified Medical Child Support Order (QMCSO) entered by a court of proper jurisdiction or administrative agency. Only Dependents who are eligible Dependents under this Plan can receive benefits. The QMCSO must be approved by the Plan. The Plan has adopted procedures for QMCSOs. These procedures are available upon request from the Fund Office.

In addition, a Dependent does not include the spouse of a married child or a minor child of a Dependent.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the health of the individual (or with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy;
2. Serious dysfunction of any bodily organ or part; or
3. Serious impairment of bodily functions; or
4. With respect to a pregnant woman who is having contractions:
 - A. That there is inadequate time to effect a safe transfer to another Hospital before delivery, or
 - B. That transfer may pose a threat to the health or safety of the woman or the unborn child.

Essential Health Benefits: Those benefits considered essential under the Patient Protection and Affordable Care Act of 2010, and regulations and other guidance issued thereunder. In general, the Act provides that Essential Health Benefits are benefits in ten different categories which are provided by a “typical employer plan.”

Experimental or Investigative: A service, procedure, drug, device, or treatment modality for a specific diagnosis that:

1. Has failed to obtain final approval for use as a specific service, procedure, drug, device, or treatment modality for a specific diagnosis from the appropriate governmental regulatory board;
2. Reliable evidence does not establish a consensus conclusion among experts recognizing the safety and effectiveness of the specific service, procedure, drug, device, or treatment modality on health outcomes for a specific diagnosis;
3. Reliable evidence shows that the drug, device, medical treatment, or procedure is the subject of on-going Phase I or Phase II clinical trials, is in the research, Experimental, study, or investigational arm of on-going Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or

DEFINITIONS

4. Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence means only published reports and articles in the authoritative medical and scientific literature, the written protocol or protocols used by the treating facility or the protocols of another facility studying substantially the same drug, device, medical treatment, or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, or procedure.

The Trustees have the authority to determine, in their discretion, whether a service, procedure, drug, device, or treatment modality is Experimental or Investigative, regardless of whether it has been prescribed, ordered, recommended, or approved by a Physician.

Fund or Plan: The Sheet Metal #10 Benefit Fund and the Plan of benefits provided thereunder, as described in this document, and as amended from time to time by the Board of Trustees.

Fund Administrator: The Fund's Board of Trustees.

Fund Office: The business office of the Sheet Metal #10 Benefit Fund.

Home Health Care Agency: Any of the institutions listed below:

1. Hospital;
2. Visiting nurse licensed by the state where care is given; or
3. Nonprofit or public health agency or other organization licensed as a home health agency that provides medical services to the patient in his/her home.

Home Health Care Plan: A plan for your continued care and treatment while under the care of a Physician. A Home Health Care Plan must be:

1. Approved by the attending Physician and the home health care provider; and
2. Reviewed at least every 30 days and reapproved in writing at least every 60 days.

Hospice Agency: A public or private organization that:

1. Administers and provides hospice care; and
2. Is either:
 - a. Licensed or certified as such by the State in which it is located;
 - b. Certified (or is qualified and could be certified) to participate as such under Medicare;
 - c. Accredited as such by the joint commission on the accreditation of Hospitals; or
 - d. Able to meet the standard established by the national hospice organization.

DEFINITIONS

Hospice Plan: A coordinated, interdisciplinary program to meet the physical, psychological, and social needs of terminally ill persons and their families:

1. By providing palliative (pain controlling) and supporting medical, nursing and other health services; and
2. Be provided through home or inpatient care during the sickness or bereavement.

Hospice Services: Any services provided:

1. Under a Hospice Plan; or
2. By a Hospital or related institution, home health agency, hospice or other facility licensed by the state to operate a hospice.

Hospital: A place that is licensed, certified or accredited as a Hospital, operated for the care and treatment of resident inpatients, and has registered graduate nurses always on duty, access to a laboratory and operating room where major Surgical Procedures are performed by legally qualified Physicians. In no event will the term Hospital include an institution or that part of an institution that is used principally as a clinic, convalescent home, rest home, nursing home, or home for the aged.

For paying benefits for mental or nervous disorders, Hospital also means a place, other than a convalescent, nursing, or rest home that has:

1. Accommodations for resident patients;
2. Facilities for the treatment of mental or nervous disorders;
3. A resident psychiatrist always on duty or call; and
4. As a regular practice, charges the patient for the expense of confinement.

For paying benefits for Alcoholism, Chemical Dependency, or Drug Addiction, Hospital confinement also means confinement in a residential primary treatment program, as licensed by the state, pursuant to a diagnosis or recommendation by a Physician or an employee assistance program employed by the Fund.

Local #10 or Union: Sheet Metal Workers International Association Local #10, its successors, and any other union that becomes party to the Trust Fund's agreement and declaration of trust.

Medically Necessary or Medical Necessity: A service or supply that is required to treat a medical condition or symptom(s). In the case of inpatient admissions, the medical condition or symptoms must require inpatient treatment for these admissions to be considered Medically Necessary. The Board of Trustees has the sole discretion of determining whether a service or supply is Medically Necessary, regardless of whether it is ordered by a Physician.

Medicare: The two health care programs, Part A - a Hospital benefit plan, and Part B - a supplementary medical benefits plan, which are established by Title XVIII of the Social Security Act of 1965, as amended. Medicare also includes Part D - prescription drug coverage, established by the Medicare Modernization Act of 2003.

Medicare Benefits: Benefits for services, supplies and prescription drugs that the eligible person receives or is entitled to receive under Medicare Part A, B or D.

DEFINITIONS

Mental Health Disorder: A mental or behavioral disorder as defined in the then-current International Classification of Diseases, Chapter V, Blocks F00 through F09, F20 through F69, and F90 through F99. Mental Health Disorder does not include a mental or behavioral disorder due to psychoactive substance use (Blocks F10 through F19), mental retardation (Blocks F70 through F79), or disorders of psychological development (Blocks F80 through F89).

Non-Occupational Injury or Disease: An injury or disease that does not arise from, is not caused by, contributed to by, or is a consequence of, any disease that arises out of or in the course of any employment or occupation for compensation or profit.

Obstetrical Procedure: Any of the procedures listed below:

1. An abdominal operation for extra-uterine pregnancy;
2. The delivery of a child or children by means of a cesarean section;
3. The delivery of a child or children by means other than a cesarean section;
4. Services in connection with a miscarriage, with or without dilation and curettage; or
5. All surgical and anesthesia benefits are payable for charges incurred by a Physician, including a certified nurse midwife, for the performance of an Obstetrical Procedure.

Participant(s): Retiree (s) and/or Dependent who are eligible for benefits under this Plan according to the eligibility section.

Physician: A person who is duly licensed to practice medicine and to prescribe and administer all drugs not including narcotic drugs. The term Physician will also include, except where specifically stated otherwise, licensed chiropractors, dentists, podiatrists, chiropodists, osteopaths, psychiatrists, certified nurse midwives, licensed psychologists, licensed social workers (LCSW), nurse practitioners, and clinics licensed by appropriate state agencies, operating within the scope of their licenses.

Pre-Natal Care: Care provided to a pregnant woman for care related to maternity services prior to the end of pregnancy.

Pre-Operative Care: Care provided by the operating Physician in connection with a Surgical Procedure during the period of continuous Hospital confinement during which the Surgical Procedure is performed, or a period of not more than seven days preceding the date of the surgical procedure, whichever is longer.

Post-Natal Care: Care provided a pregnant woman for care related to maternity services during the 90-day period following the end of pregnancy. **Post-natal care** does not include any care provided to the newborn child or children.

Post-Operative Care: Care rendered by the operating Physician in connection with a Surgical Procedure during the period of continuous Hospital confinement during which the Surgical Procedure is performed or a period of not more than 14 days following the date of the Surgical Procedure, whichever is longer.

Qualified Medical Child Support Order (QMCSO): A judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction requiring that a medical child support order recognize an eligible Retiree's child as an alternate recipient. **NOTE:** A dependent child cannot be added to coverage under the Plan after you retire unless they were previously enrolled as a Dependent under the Active Plan.

DEFINITIONS

Reasonable and Customary: The usual and customary charge for the services provided and the supplies furnished in the area where such services are provided or supplies are furnished. The actual charges of a Hospital or Physician for the particular service rendered to the extent that the charge is reasonable and does not exceed the customary charge or fee for comparable services charged by Hospitals or Physicians within the applicable geographic area with training, experience, and professional standing comparable to the Hospital or Physician that renders the service. The Fund bases its determination on the use of national databases of health care charges and takes into account the geographic region where the services were provided.

Respite Care: A short-term inpatient hospice stay that may be necessary for a hospice patient to give temporary relief to a Caregiver who regularly assists with home care. Each respite care stay is limited to five days.

Sheet Metal Workers Local #10 Pension Plan, Sheet Metal Local 10 Supplemental Retirement Plan and Production Sheet Metal Workers' Local 10 Retirement Plan: the Retirement Income Plans sponsored by Local #10.

Sheet Metal Workers National Pension Plan: The retirement plan sponsored by the Sheet Metal Workers International Association.

Skilled Nursing Care Confinement: Confinement in a skilled nursing care facility:

1. Upon the specific recommendation and under the general supervision of a legally qualified Physician;
2. Beginning within 14 days after discharge from a required Hospital confinement for a period of at least three days for which room and board benefits are paid, or if longer, for an eligible person who would need to be re-admitted to a Hospital without the skilled nursing care; and
3. For receiving Medically Necessary care for convalescence from the conditions causing or contributing to the preceding Hospital confinement.

Skilled Nursing Care Facility: An institution or that part of any institution that operates to provide convalescent or nursing care and:

1. Is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require Medically Necessary care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons;
2. Has policies, which are developed and periodically reviewed by a group of professional personnel, including one or more Physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services provided;
3. Has a Physician, a registered professional nurse or a medical staff responsible for the execution of such policies;
4. Has a requirement that the health care of every patient be under the supervision of a Physician and provides for having a Physician available to furnish necessary medical care in case of emergency;
5. Maintains clinical records on all patients;

DEFINITIONS

6. Provides 24-hour nursing services that is sufficient to meet nursing needs in accordance with the policies developed and has at least one registered professional nurse employed full-time;
7. Provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;
8. In the case of an institution in any state in which state or applicable local law provides for the licensing of institutions of this nature is:
 - a. Licensed pursuant to such law; or
 - b. Approved by the agency of the state or locality responsible for licensing institutions of this nature as meeting the standards established for such licensing; and
9. Meets any other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to their physical facilities.

Specialty Drug: A medication as determined by Blue Cross Blue Shield of Minnesota that typically requires:

1. Close supervision and monitoring;
2. Frequent dosage adjustments;
3. Special storage, handling, and administration; and
4. Significantly higher costs than traditional drugs.

Substance Use Disorder: A mental or behavioral disorder due to due psychoactive substance use as defined in the then-current International Classification of Diseases, Chapter V, Blocks F10 through F19.

Surgical Procedure: Means a procedure performed for the purpose of structurally altering the human body by incision or destruction of tissues and is part of the practice of medicine for the diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transportation of live human tissue, which include lasers, ultrasound, ionizing radiation, scalpels, probes, and needles. During surgery the tissue can be cut, burned, vaporized, frozen, sutured, probed, or manipulated by closed reduction for major dislocation and fractures, or otherwise altered by any mechanical, thermal, light-based electromagnetic, or chemical means. Injection of diagnostic or therapeutic substances into body cavities, internal organs, joints, sensory organs, and the central nervous system is also considered to be a Surgical Procedure.

Terminally Ill: A participant for whom a Physician has determined:

1. There is no reasonable prospect for cure; and
2. The life expectancy is six month or less.

Trustees or Board of Trustees: The Trustees of the Sheet Metal #10 Benefit Fund.

ELIGIBILITY RULES FOR RETIREES

When You Retire

When you retire, coverage for you and your *Dependents* will end under the Active Plan at the end of month with your last day worked unless you use dollar bank reserves to continue active coverage for a maximum of three months. You may exhaust the remainder of your bank for retiree coverage in this Plan. Additionally, you may use your SAFE Plan account balance to maintain coverage under this Plan. You may be eligible for retiree coverage if you meet the eligibility requirements or you can elect COBRA Continuation Coverage if eligible. Note that your dollar back is not a vested benefit.

You are eligible for coverage if you:

1. Made written application to the Board of Trustees within 31 days following the date your active coverage under this Plan ends. Date of Retirement” as used in this booklet means the day you voluntarily remove yourself from covered employment; and
2. Are eligible to receive a pension from one of the following: Sheet Metal Workers Local #10 Pension Fund, the Sheet Metal Local #10 Supplemental Retirement Fund, the Sheet Metal Workers National Pension Fund and/or the Production Sheet Metal Workers’ Local 10 Retirement Plan; and
3. Had at least 11,500 hours of contributions paid to the Plan on your behalf while you were an Active Employee. The 11,500 hours of continuous service must occur immediately preceding retirement; and
4. If you are a Non-Bargaining Unit Employee, then you must have eighty-two (82) months of coverage reported to the Fund immediately preceding your retirement; and
5. At the time of your application for coverage, and at any time thereafter, you are not performing the same or similar work in the same or similar industry in which you worked while active and for which contributions were required to the Fund pursuant to a collective bargaining agreement.

When you retire, you may be able to:

- *Elect retiree coverage; or*
- *Elect COBRA Continuation Coverage.*

For general eligibility, the Plan may recognize contributions and/or service for participants (according to the respective merger agreements) of local unions that have been merged into Sheet Metal #10 Benefit Fund. The Board of Trustees will determine what records provide the best evidence of a participant’s history with a merged local union’s prior health plan, and the Board of Trustees will utilize that history for determining eligibility.

If you participate in this Plan, and return to active employment, re-entry to the Retiree Plan will be based on the prior 11,500 hours.

Disabled Employee Eligibility

You are eligible for coverage as a Disabled Employee if you:

ELIGIBILITY RULES

1. Retired before you reached age 55 on a Pension from either the Sheet Metal Workers Local #10 Pension Fund, the Sheet Metal Local #10 Supplemental Retirement Fund, the Sheet Metal Workers National Pension Fund and/or the Production Sheet Metal Workers' Local 10 Retirement Plan;
2. Retired because of a disability that prevented you from performing the duties required of a sheet metal worker;
3. Had at least 11,500 hours of employer contributions made on your behalf immediately preceding your disability;
4. Did not qualify for benefits from Medicare (*If you qualify for Medicare benefits from Social Security, then you are eligible for normal Retiree Coverage.*); and
5. Apply for and made the required contributions to the Fund for this coverage.

You can change from this Disability Continuation Coverage to Retiree Plan coverage at age 55.

Effective Date of Retiree Benefits

Your retiree benefits are effective on the date you meet the definition of a Retiree.

Self-contributions

A self-contribution is required for you and your eligible Dependents to remain eligible. Self-contributions are paid monthly. The amount of the self-contribution will be determined by the Trustees based on the benefit costs and administrative expenses.

Self-contributions must be received in full by the Fund Office on the first day of the month. Self-contributions received after this deadline will not be accepted and your eligibility and your Dependent's eligibility for benefits will end on the last day of the month preceding the month for which contributions were due.

Example: If the contribution due on May 1 is not received until May 10, then your coverage will be terminated on April 30.

Self-contributions must be made for consecutive months so that there is no break in eligibility. In the event that eligibility for benefits ends because of your failure to make self-contributions, then you and/or your Dependents will lose the right to make future self-contributions.

Qualified Medical Child Support Orders (QMCSO'S)

If a copy of a Medical Child Support Order as defined in ERISA Section 609(a), or other order designating medical child support, is filed with the Fund Office, the Fund Administrator shall promptly notify the Retiree and each alternate recipient of the receipt of such order and the Plan's procedure for determining whether the order is a Qualified Medical Child Support Order [QMCSO], as further

ELIGIBILITY RULES

defined in ERISA Section 609(a). **Please note that the Plan does not permit retirees to add dependent children (or spouse) to coverage under the Plan after they retire.**

TERMINATION OF ELIGIBILITY

Your coverage will stop on the earliest of:

1. The day that your pension from the Sheet Metal Workers Local #10 Pension Fund, the Sheet Metal Local #10 Supplemental Retirement Fund, the Sheet Metal Workers National Pension Fund and/or the Production Sheet Metal Workers' Local 10 Retirement Plan ceases or is suspended unless any one of these Funds allows for such work to occur. You will remain eligible under this Retiree Plan until you become eligible under the Active Plan;
2. The last day of the month for which self-contributions were last made;
3. The day you re-establish your eligibility for Active Employee benefits in accordance with the Eligibility Rules;
4. The day you return to work in the sheet metal trade in the jurisdiction of the Sheet Metal #10 Benefit Fund if contributions are not being remitted to the Benefit Fund for such work; or
5. The date the Plan ends.

Termination of Eligibility for Dependents

The eligibility of your Dependents will terminate on the earliest of the following dates:

1. The date your eligibility under the Plan terminates;
2. The date your Dependent no longer meets the definition of Dependent;
3. The date your Dependent becomes eligible for coverage under the Active Plan;
4. The date your Dependent enters the uniformed services or enrolls in coverage under the United States; or
5. The date the Plan ends.

In certain situations, a Dependent who loses coverage under the Plan will have the right to elect Continuation of Coverage under COBRA.

Keep Your Plan Informed of Address Changes

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

Retirees Who Return From Service With the International Union

If you go to work for the International Union or a National or Regional Fund of another related entity, you will be placed on grace period status while in that employment.

TERMINATION OF ELIGIBILITY

When you retire from or discontinue that employment and meet all of the above requirements, you will be able to resume participation in this Fund as a retiree with either:

1. The normal retirement benefits at the normal retirement rates, or
2. The same medical benefits an Active Employee receives except for Life, AD&D and Weekly Accident and Sickness Benefits. These benefits are provided at the rates currently in effect for disabled individuals.

Retiree Benefits – Non-Bargained Employees

Non-Bargained Employees are eligible for retiree benefits under different rules than Collectively Bargained Employees. For purposes of calculating 11,500 hours, please note it is equivalent to 82 months. Contact the Fund Office for a complete description of these rules.

Supplemental Medicare Wraparound Plus Plan (SMW+)

The Sheet Metal Workers National Pension Fund currently sponsors a supplement to Medicare called the SMW+ Plan. If you are eligible for coverage under the SMW+ Plan and do not make the election to participate, then benefits under this Plan will be paid as if you had made the election.

Re-retirement

If you retired, reestablished your eligibility as an Active Employee and then re-retire, you and your eligible Dependents will again become eligible for retiree benefits by making another written application to the Board of Trustees no later than 31 days following the date of your second retirement.

Retiree Opt-Out of Benefits

As a Retiree with coverage under the Plan you have the right to exercise an opt-out from coverage if you have other coverage available to you. Other coverage could be coverage through your spouse, another employer, a State or Federal Exchange, the Veteran's Administration or other private insurance.

To opt-out of coverage you must show proof of other Creditable Health Coverage upon opting out and upon opting back into the Plan. If you opt-out, you will later be able to re-enroll in coverage under the Plan upon your submission of evidence of any of the following events:

- You or your spouse lose coverage as a result of retirement, termination of employment (voluntary or involuntary) or reduction in hours; or
- A significant increase in the cost you pay (defined as an increase of 50% or more) for the coverage available; or
- You are no longer eligible as a dependent under your spouse's plan due to death, divorce or legal separation (in this case only the member may enroll); or
- Medicare eligibility for you, and/or your spouse who is no longer working; or
- Open enrollment in November for January 1st effective date.

TERMINATION OF ELIGIBILITY

Any available individual dollar bank or SAFE Fund balance will be “frozen” upon your electing to opt-out of coverage under the Plan and will be available for use should you later re-enroll in Retiree Coverage under the Plan. Note that your dollar bank is not a vested benefit.

Please note that you and your spouse must each re-enroll in the Plan upon your attainment of Medicare eligibility, unless you continue to be covered as an active employee in an employer sponsored plan. You should notify the Fund Office before your 65th birthday or eligibility for Medicare to protect your Retiree Coverage rights.

SPECIAL DEPENDENT CONTINUATION COVERAGE

If you die while covered under this Plan, coverage for your eligible Dependents will continue as long as they meet the definition of Dependent and they pay the required self-contributions when due. If your Dependent becomes eligible for other coverage, Special Dependent Continuation Coverage terminates.

Surviving Dependents must make the required self-contributions when they are due so that coverage remains continuous. The Fund's third-party administrator must receive the first monthly self-contribution by the end of the month after the beginning of the month for which such self-contribution applies. Subsequent self-contributions are due at the Fund's third-party administrator on the first day of the month for which they are due. Self-contributions received after these deadlines will not be accepted and the Dependent's coverage will end as of the first day of the month for which self-contributions were due and not paid.

An election of this Special Dependent Continuation Coverage is a rejection of COBRA Continuation Coverage. Conversely, an election of COBRA is a rejection of this Special Dependent Continuation Coverage.

COBRA CONTINUATION COVERAGE

Once you have elected Retiree Coverage, then you are not entitled to subsequent COBRA Continuation Coverage. However, once you have elected Retiree Coverage, your dependents are entitled to subsequent COBRA Continuation Coverage.

COBRA Continuation Coverage is offered to qualified beneficiaries in specific instances, called qualifying events, when coverage under the Plan would otherwise end. A qualified beneficiary is a Dependent of an eligible retiree who is covered under the Plan on the day before a qualifying event.

In compliance with a federal law commonly called COBRA, this Plan offers covered Dependents (called qualified beneficiaries) of eligible Retirees the opportunity to elect a temporary continuation (COBRA Continuation Coverage) of the Plan's healthcare coverage. This coverage includes medical, prescription drug and hearing benefits when that coverage would otherwise end because of certain events (called qualifying events). Qualified beneficiaries who elect COBRA Continuation Coverage must pay for it. Retirees cannot be qualified beneficiaries.

Who is Entitled to COBRA Continuation Coverage

Each qualified beneficiary can elect COBRA Continuation Coverage when a qualifying event occurs. As a result of that qualifying event, that person's healthcare coverage ends, either as of the date of the qualifying event or as of some later date. A parent or legal guardian may elect COBRA for a minor child. A qualified beneficiary also has the same rights under the Plan as other covered individuals.

A qualified beneficiary is a Dependent of an eligible Retiree who was covered by the Plan when a qualifying event occurred. A child who becomes a Dependent child by birth, adoption, or placement for adoption with you during a period of COBRA Contribution Coverage is also a qualified beneficiary. A person who becomes your spouse during a period of COBRA Continuation Coverage is not a qualified beneficiary. You must notify the Fund Office within 31 days after the date of marriage, birth, adoption or placement for adoption, or loss of full-time student status.

COBRA Qualifying Events

A qualifying event triggers the opportunity to elect COBRA when your **Dependent** loses coverage under this Plan. Qualified beneficiaries are entitled to COBRA Continuation Coverage when qualifying events occur and cause coverage to end.

The following chart lists the COBRA qualifying events, who can be a qualified beneficiary, and the maximum period of COBRA Continuation Coverage.

Maximum COBRA Continuation Coverage period for qualified beneficiaries			
Qualifying event causing healthcare coverage to end	<i>Retiree</i>	<i>Spouse</i>	<i>Dependent child(ren)</i>
Death	N/A	36 months	36 months
Divorce or legal separation	N/A	36 months	36 months
Eligibility as a Dependent child under the plan ends	N/A	N/A	36 months

COBRA CONTINUATION COVERAGE

Special Enrollment Rights

If your Dependents' coverage ends because of a qualifying event, your Dependents have special enrollment rights for 30 days after coverage loss to enroll under another group health plan, in which they are eligible; i.e. a plan sponsored by your spouse's employer. However, the Plan does not permit you to enroll Dependent children after you have retired.

Maximum Period of COBRA Continuation Coverage

The maximum period of COBRA Continuation Coverage is generally either 18 months or 36 months, depending on which qualifying event occurred, measured from the time the qualifying event occurs.

When The Plan Must Be Notified of a Qualifying Event

To elect COBRA Continuation Coverage after a divorce, legal separation, or a child ceasing to be a Dependent under the Plan, you and/or a family member **must inform the Plan in writing of that event no later than 60 days after that event occurs.** The notice should be sent to the Fund Office as listed in the *Important Contact Information* section. **If notice is not received by the Fund Office within the 60-day period, the qualified beneficiary will not be entitled to elect COBRA Continuation Coverage.**

Notices Related to COBRA Continuation Coverage

The Fund Office will notify your covered Dependents of the date coverage ends and the information and forms needed to elect COBRA Continuation Coverage when:

- You die; or
- You notify the Fund Office that a Dependent is no longer eligible, you are divorced, or you have become legally separated. *Note: failure to notify the plan in a timely fashion may jeopardize your Dependent's rights to COBRA Continuation Coverage.*

Your covered Dependents have **60 days** from the date you receive notice to elect COBRA Continuation Coverage. If you and/or any of your Dependents do not choose COBRA Continuation Coverage within 60 days after receiving notice, they will have no group health coverage from this plan after the date coverage ends.

If your Dependents elect COBRA Continuation Coverage, your Dependents will be entitled to the same health coverage that you had when the event occurred that caused their health coverage under the plan to end but your Dependents must pay for it. If there is a change in the health coverage provided by the Plan, the change will apply to your COBRA Continuation Coverage.

If the Plan is notified of a qualifying event but the Fund Office determines that your Dependents are not entitled to the requested COBRA Continuation Coverage, your Dependents will be sent an explanation indicating why COBRA Continuation Coverage is not available. This notice will be sent according to the same timeframe as a COBRA Election Notice.

COBRA CONTINUATION COVERAGE

Paying for COBRA Continuation Coverage

Your Dependents must pay the monthly contribution, as established by the Board of Trustees, for COBRA Continuation Coverage. Your Dependents will be told the exact dollar charge for the COBRA Continuation Coverage that is in effect at the time they become eligible for COBRA Continuation Coverage. The cost of the COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

The initial payment for the COBRA Continuation Coverage is due to the Fund Office 45 days after COBRA Continuation Coverage is elected. Your Dependents will be billed for the first day of the month following the month they lose eligibility. Full payment must be received by the Fund Office by the last day of the month for which the self-contribution is due. If payment is not received, then COBRA Continuation Coverage will not take effect.

Your Dependents will NOT receive a bill for COBRA after the initial notices and elections.

COBRA Cancellation for Non-Payment

After the initial COBRA payment, subsequent payments are due on the first day of each month, but there will be a 30-day grace period to make those payments. Self-contributions must be made for consecutive months for coverage to remain continuous.

<i>If your Dependents miss a COBRA self-payment, then they will lose COBRA Continuation Coverage.</i>

If payments are not made by the due date, COBRA Continuation Coverage will be canceled as of the due date. Payment is considered made when it is postmarked. Payments post marked after the deadline will not be accepted and your Dependents' coverage will be terminated as of the first day of the month for which the self-contribution was due.

Disability Extension of COBRA Continuation Coverage 18-Month Period Only

If your Dependent is determined by the Social Security Administration to be disabled and your Dependent notifies the Plan in a timely fashion, your Dependent may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. Your Dependent must notify the Fund Office in writing within 60 days of the date of the determination.

Second Qualifying Event Extension of COBRA Continuation Coverage 18-Month Period Only

If your Dependents experience another qualifying event while receiving 18 months of COBRA Continuation Coverage, then your Dependents can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the plan. This extension may be available to your Dependents receiving COBRA Continuation Coverage if:

- You die;

COBRA CONTINUATION COVERAGE

- You get divorced or legally separated; or
- Your Dependent child stops being eligible under the plan.

The extension is available only if the event would have caused your Dependent to lose coverage under the Plan had the first qualifying event not occurred. The Fund Office must receive notification within 60 days after the date that the second qualifying event occurs.

Early Termination of COBRA Continuation Coverage

Once COBRA Continuation Coverage has been elected, it may end on the earliest of following:

- The date the Fund no longer provides group health coverage;
- The first day of the time period for which the amount due for the COBRA Continuation Coverage is not paid on time;
- The date, after the date of the COBRA election, your Dependent first becomes entitled to **Medicare**;
- The date, after the date of the COBRA election, your Dependent first becomes covered under another group health plan and that plan does not contain a pre-existing condition provision; and
- During an extension of the maximum coverage period to 29 months due to the disability of your Dependent, when the disabled person is determined to not be disabled.

Notice of Early Termination of COBRA Continuation Coverage

The Plan will notify a qualified beneficiary if COBRA Continuation Coverage ends earlier than the end of the maximum period of coverage applicable to the qualifying event. The notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA Continuation Coverage terminated, and any rights the qualified beneficiary may have under the plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the Fund Office determines that COBRA Continuation Coverage will terminate early.

Certification of Coverage When Coverage Ends

When your Dependents' coverage ends, the Fund Office will provide your covered Dependents with a certificate of creditable coverage that indicates the period of time they were covered under the Plan. The certificate will indicate the period of time they were covered under this Plan, and certain additional information that is required by law.

The certificate will be sent by first class mail shortly after coverage under this Plan ends. This certificate will be in addition to any certificate provided to you after their group health coverage terminated.

The Fund will send a certificate, if your Dependents' request is received by the Fund Office within two years after the later of the date your coverage under this plan ended or the date COBRA Continuation Coverage ended.

If your Dependents become Medicare-eligible, then their rights to continuation coverage ends.

LIFE EVENTS

Your benefits are designed to adapt to your needs at different stages of your life. Since different Life Events can affect your benefits coverage, this section describes how your coverage is affected and what you may need to do when different events occur.

Getting Married

You may not add a Spouse subsequent to your election for Retiree coverage.

If I am the surviving spouse of the Participant and I get re-married

You are no longer eligible for coverage and must inform the Fund Office.

Adding A Child

You may not add a Child subsequent to your election for Retiree coverage.

Getting Legally Separated or Divorced

After legal separation or divorce, your ex-spouse will no longer be eligible for coverage. However, under COBRA, an ex-spouse may elect to continue Fund coverage unless your ex-spouse is Medicare-eligible.

In addition, you may be required to provide medical benefits for your dependent child(ren) through a court order called a Qualified Medical Child Support Order (QMCSO), which is subject to Plan eligibility rules which provide that you may not add a Child subsequent to your election for Retiree coverage.

What You Need to Do

You or your ex-spouse must notify the Fund Office within 60 days of the divorce or legal separation date for your ex-spouse to obtain COBRA Continuation Coverage.

Please notify the Fund Office if your situation involves a QMCSO. You or your Dependent may request a free copy of the Fund's QMCSO procedures for handling such orders.

Child Losing Eligibility

Your child is no longer eligible for coverage when he or she no longer meets the Plan's definition of an eligible Dependent child. If your child loses eligibility, your child may elect to continue coverage under COBRA (see above).

Taking A Military Leave

If you enter into military service (active duty or inactive duty training) for up to 31 days, your health coverage will continue as long as you make the required self-payment. If you are called into military service for more than 31 days, you may continue your coverage by paying the required self-payments for up to 24 months or, if sooner, the end of the period during which you are eligible to apply for

LIFE EVENTS

reemployment in accordance with the uniformed services employment and reemployment rights act of 1994 (USERRA).

Your coverage will continue to the earliest of the following:

- The date you and/or your Dependents do not make the required self-payments;
- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA;
- The last day of the month after 24 consecutive months; or
- The date the Fund no longer provides any group health benefits.

If You Do Not Continue Coverage Under USERRA

If you do not continue coverage under USERRA, your coverage will end immediately when you enter active military service. Your Dependents will have the opportunity to elect COBRA Continuation Coverage.

What You Must Do

You must notify the Fund Office in writing when you enter the military and when you are discharged. For more information about self-payments under USERRA, contact the Fund Office.

What if I die

Your Covered Dependents will be eligible for Continuation Coverage as stated on pp. 23-27 of this SPD.

MAJOR MEDICAL EXPENSE BENEFIT

The major medical expense benefit encompasses a wide range of medical benefits.

How The Plan Works

Annual Deductible

You must pay the annual deductible, before the Plan begins to pay any benefits. The deductible applies only once in any calendar year even though you may have several different injuries or diseases. The deductible applies to each eligible family member, up to the family maximum of three deductibles per family, as shown in the Schedule of Benefits.

Coinsurance

After you pay the annual deductible, you and the Plan share in the cost of covered medical expenses. The Plan's coinsurance is a specified percentage of covered medical expenses, and your coinsurance is the balance of the percentage up to 100%, until you have reached your out-of-pocket maximum. Please refer to the Schedule of Benefits for the specific percentages. After you have reached your out of pocket maximum, the Plan pays 100% of covered medical expenses for the remainder of the calendar year.

Annual Out-of-Pocket Maximum

The percentage of covered medical expenses that you pay accumulates into your annual out-of-pocket maximum. Once you reach your out-of-pocket maximum as shown in the *Schedule of Benefits*, the Plan will pay 100% of covered medical expenses for the rest of the calendar year. The out-of-pocket maximum does not include expenses used to reach your deductible, any expenses over any special annual or lifetime limits, and any expenses that are not covered medical expenses. For example, prescription drug costs do not apply to the annual out-of-pocket maximum.

Benefit Substitution

Benefit substitution is a process by which the Fund's case manager works with you, your family, and your healthcare providers to substitute one covered benefit for another covered benefit when:

- A specific plan benefit has been depleted;
- The care is Medically Necessary and is not custodial in nature;
- You still require the current level of care or services;
- Without the continued care, your condition would deteriorate and/or require a higher level of care; and
- Continued coverage for the services would be more (or at least as) cost-effective as paying for a higher level of care.

Coverage is provided in an amount the Board of Trustees determines after review. Retrospective requests for benefit substitution are not eligible. Benefit substitution is not available to allow coverage for Plan exclusions.

MAJOR MEDICAL EXPENSE BENEFIT

Covered Major Medical Expenses

Covered Major Medical expenses are the Reasonable and Customary charges for the following Medically Necessary services and supplies required for the treatment of a Non-Occupational Injury or Disease up to the limits shown in the *Schedule of Benefits*:

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, the Plan provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

Treatment of Mental Health Disorders and Substance Use Disorders

Treatment of Mental Health Disorders and Substance Use Disorders by a Physician or Mental Health Professional is covered as shown in the *Schedule of Benefits*.

Nondiscrimination – Patient Protection and Affordable Care Act

The Plan will comply with the nondiscrimination provisions of Section 1557 of the Patient Protection and Affordable Care Act and its accompanying regulations and will not discriminate on the basis of race, color, national origin, sex, age or disability in its health programs and activities.

Home Health Care Benefit

Covered expenses for home health care services and supplies furnished in the patient's home by a Home Health Care Agency and according to a Home Health Care Plan will be paid up to the maximum shown in the *Schedule of Benefits*. Covered expenses are:

- Part-time or intermittent nursing care provided by a registered nurse or a licensed practical nurse supervised by a registered nurse;
- Part-time or intermittent home health aide services that consist primarily of medical care or therapy for the patient;
- Physical, occupational or speech therapy, as described in the *Schedule of Benefits*. Covered speech therapy services must be ordered and monitored by a Physician pursuant to a written treatment plan for an identifiable clinical condition submitted to and approved by the Plan. Progress reports for speech therapy services must also be submitted to the Plan by the treating Physician to demonstrate that services continue to be Medically Necessary and the treatment plan has a reasonable expectation to produce progress; or
- Prescription drugs, medical supplies, and related pharmacy and laboratory services, which are prescribed by a Physician and would be covered under the Plan if the patient is confined to a Hospital.

The Home Health Care Plan must be:

- Approved in writing and established by the attending Physician with the home health care provider; and

MAJOR MEDICAL EXPENSE BENEFIT

- Reviewed at least every 30 days.

The Home Health Care Benefit will not be paid for services:

- That consist primarily of the duties of a housekeeper, companion or sitter;
- And supplies not included in the Home Health Care Plan;
- Of a person who is a family member or lives with you in your home;
- Provided outside the patient's home; and
- Specifically excluded by the Plan.

Other Covered Expenses

In addition to the above, these services are also covered:

1. In-network Hospital room and board charges up to the standard daily rate for the Hospital's most common type of room (the Plan does not cover out-of-network inpatient hospital stays, but will cover Emergency Medical Conditions treated at an out-of-network inpatient hospital).
2. Hospital services and supplies, other than room and board.
3. Physician and Mental Health Professionals charges.
4. Services of a registered graduate nurse (R.N.), registered nurse practitioner, licensed practical nurse (L.P.N.), and legally licensed physiotherapist. These services must not be provided by a member of your, or your spouse's, immediate family.
5. Diagnostic laboratory and x-ray examinations. (See the *Schedule of Benefits* for information on medical imaging at CDI which is covered at 100% with no deductible or coinsurance).
6. X-ray, radium, and radioactive isotope therapy.
7. Anesthetics, blood, blood plasma, and oxygen.
8. Rental of durable medical equipment. The Plan may decide to purchase equipment if it determines purchase is more economical than rental. A purchase may be made even if rental payments have already been made. The Plan will provide a benefit for the replacement of durable medical equipment only when the replacement is needed due to a change in the member's physical condition or when the original equipment is inoperative and cannot be repaired at a cost less than rental or replacement. The Plan will pay for repair of inoperative equipment if less than the cost of rental or replacement. The Plan will pay the reasonable cost of rental during repair.
9. Artificial limbs, eyes, and other non-dental prosthetic devices.
10. Emergency transportation by a professional ambulance service to the nearest Hospital equipped to furnish required treatment. Emergency transportation is also covered for transportation between Hospitals when such transfer results in more highly specialized care. The Fund may require a Physician's statement certifying that the transportation was due to an emergency and that the receiving Hospital was the nearest Hospital equipped to furnish the required treatment.

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11. Dental work or oral surgery for the prompt repair of natural teeth when required because of a Non-Occupational Injury. Expenses must be incurred within six months of the injury.
12. Excision of partially or completely un-erupted impacted teeth, the excision of a tooth root without the extraction of the entire tooth, or any other incision or excision procedures on the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.
13. Reconstructive surgery, including medical and dental services, provided as an integral part of a reconstructive treatment plan to restore function to any area of the body which has been altered by disease, trauma, congenital/developmental anomalies and/or defect, or therapeutic processes, unless otherwise excluded under the Plan. This includes surgical or orthodontic treatment to correct medical complications or a post-surgical deformity, unless coverage for the prior surgery was excluded under the Plan. This other covered expense includes oral surgery and orthodontic care, rendered by Physicians or dentists under such reconstructive treatment plan.

The repair or replacement of a damaged or missing tooth or structure will be covered under this Major Medical Benefit if the treatment commences within 180 days of accidental injury. Accidental injury means injury caused by external force.

Dental services are not covered under this Major Medical Benefit if otherwise excluded by this Plan or when such services are rendered to alter or reshape normal body structures, without the loss of function, in order to improve appearance.

14. Skilled Nursing Care Facility not to exceed the:
 - a. Usual and customary charge; and
 - b. Maximum number of days payable for any one period of confinement, as shown in the *Schedule of Benefits*.

Successive periods of Skilled Nursing Care Confinement will be considered one period of confinement unless the subsequent confinement begins 60 days or more after the patient is no longer confined in either a Hospital or Skilled Nursing Care Facility.

15. Orthotics, including examination, x-rays, and impressions when prescribed by a Physician up to the amount shown in the *Schedule of Benefits*.
16. Penile prosthesis provided the implantation is performed in relation to impotence caused by an accidental bodily injury or a non-mental/nervous disease.
17. Well baby immunizations/vaccinations and office visits including sports and school exams.
18. Elective sterilization, including vasectomy and tubal ligation.
19. Educational programs for patients or parent(s) of children that teach the care and management of chronic diseases (such as diabetes, asthma, etc.) and are designed to improve patient knowledge of the disease and techniques for self-management and compliance with proper health care procedures required for the patient's well-being. Such programs are covered up to the Calendar Year and lifetime maximums shown in the *Schedule of Benefits*, when ordered by a Physician, and only if the

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Participant attended 80% or more of the scheduled classes. The Participant must submit a receipt showing the:

- a. Cost of the program;
 - b. Name, address, and telephone number of the program sponsor;
 - c. Dates and times classes were held; and
 - d. Classes actually attended by the Participant.
20. Chiropractic services, office visits to a licensed chiropractor, x-rays and diagnostic procedures up to maximum shown in the *Schedule of Benefits*. Benefits are payable only for visits at the office of a chiropractor.
 21. One wig when required to replace hair lost because of chemotherapy or illness up to the maximum shown in the *Schedule of Benefits*.
 22. One physical exam, including cancer exams, per year.
 23. Diagnosis, corrective orthopedic appliances, or surgical treatment of temporomandibular joint dysfunction (TMJ). The lifetime maximum shown in the *Schedule of Benefits* applies only for the appliances.
 24. Hearing Care, which includes one hearing examination per two consecutive Calendar Years up to the maximum benefit shown in the *Schedule of Benefits*. Also included is/are hearing aid instrument(s) up to the maximum benefit shown in the *Schedule of Benefits*. Subject to the *Schedule of Benefits*, this benefit includes replacement or repair.

Covered Expenses for Hearing Care do not include:

- a. Medical examinations that are not provided by and hearing aids that are not prescribed by a qualified otologist or otolaryngologist.
 - b. Examination by an audiologist when not referred by an otologist or otolaryngologist or when the exam is not followed by an exam by an otologist or otolaryngologist.
 - c. Rental or purchase of amplifiers or replacement batteries.
 - d. Repairs of hearing aid.
25. Hospice Services for a Participant who has been diagnosed as Terminally ill up to the lifetime maximum number of days shown in the *Schedule of Benefits*. Charges must be incurred either during a confinement in a hospice or a facility operating under the direction of a Hospice Agency following a Hospice Plan or can be incurred at home as long as Hospice Services are provided by a home health agency licensed to provide Hospice Services and in accordance with a Hospice Plan. Covered expenses include:

- a. Counseling of a Participant and the eligible Dependents; and
- b. Bereavement counseling of the eligible Dependents.

Counseling and bereavement counseling must be rendered by a:

- a. Psychiatrist;

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- b. Licensed psychologist; or
- c. Licensed social worker.

26. Inpatient hospice benefits are payable when:

- a. There are no suitable Caregivers available to provide hospice benefits;
- b. It is determined by the Hospice Agency that home hospice is impractical because the persons that regularly assist with home care find the patient is unmanageable; and/or
- c. Respite Care is needed.

Payment will **not** be made for:

- a. Hospice Services and supplies that are not part of a Hospice Plan;
- b. Services of a Caregiver or a person who lives in the Participant's home or is a member of his or her family;
- c. Domestic or housekeeping services that are unrelated to the patient's care;
- d. Services that provide a protective environment when no skilled service is required, including companionship or sitter services other than Respite Care;
- e. Services that are not directly related to a Participant's medical condition, including (but not limited to):
 - i Estate planning, drafting of wills or other legal services;
 - ii Pastoral counseling or funeral arrangement or services;
 - iii Nutritional guidance or food services such as "meals on wheels;" or
 - iv Transportation services.

27. Vision training will be covered when the vision training is considered medically necessary.

28. Occupational therapy and speech therapy.

29. All forms of prescription birth control are covered. Coverage is limited to methods of birth control that are available only with a Physician's prescription, and includes, but is not limited to, birth control pills, patches, and injections; diaphragms; and intrauterine devices (IUD's).

30. Specialty Drugs as described on page 40.

31. Bariatric surgery, subject to the following limitations:

- a. Services for bariatric surgery must be obtained from a Blue Distinction Center for bariatric surgery;
- b. Medically Necessary inpatient and outpatient services for bariatric surgery are limited to a lifetime coverage maximum of \$20,000; and
- c. Prior authorization is required. All prior authorizations should be submitted in writing to:

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Blue Cross and Blue Shield of Minnesota, Medical Review Department,
P.O. Box 64265, St. Paul, MN 55164.

- * Blue Distinction Centers for Bariatric Surgery are designated facilities within participating Blue Cross and/or Blue Shield providers that have been selected after a rigorous evaluation of clinical data measures established in collaboration with leading doctors, medical societies, and professional organizations.

For a list of Blue Distinction Centers for Bariatric Surgery call the customer service number on your ID Card or visit the BCBS website at www.bluecrossmn.com.

Approval for Bariatric Surgery will be based on a number of factors including body mass index (BMI), morbid obesity, history of failure to sustain weight loss, the results of a mental health evaluation, patient expectations for surgery, the patient's understanding of the risks, benefits and uncertainties of a given Surgical Procedure and the patient's treatment plan, including pre- and post-operative dietary evaluations.

As technology changes, the covered bariatric surgery procedures will be subject to modifications in the form of additions or deletions when appropriate.

32. A prophylactic mastectomy will be covered when an eligible person has:
- a. Tested positive for the BRCA 1 or BRCA 2 gene mutation; or
 - b. A history of cancer in the contralateral breast; or
 - c. A strong family history of breast cancer.

A prophylactic oophorectomy and/or hysterectomy will be covered when an eligible person has:

- a. Tested positive for the BRCA 1 or BRCA 2 gene mutation; or
- b. A strong family history of ovarian cancer.

A strong family history means that at least two of your first-degree relatives or three of your second-degree relatives have been diagnosed with such cancer. The term "first-degree relatives" means your mother or sisters. The term "second-degree relatives" means your aunts or grandmothers.

33. Lodging benefit: A lodging benefit of up to \$30 per night is available when daily proximity is necessary in order to participate in a lengthy Medically Necessary treatment program. The benefit will pay for up to 90 nights. Lodging benefits will be paid only if you satisfy the following requirements:
- a. You must obtain a letter from your attending Physician detailing: (1) your diagnosis; (2) procedure; (3) required proximity; (4) length of treatment; and (5) treatment facility. The letter must also contain a detailed explanation of the necessity for daily proximity in order to participate in the lengthy Medically Necessary treatment program,

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- b. You must apply and receive approval from the Plan Administrator for this benefit prior to your Medically Necessary procedure;
- c. You must obtain lodging within the proximity of the medical facility as required by your attending Physician; and
- d. You must provide a receipt to the Plan Administrator to receive the \$30 per night benefit.

To apply for benefits, you should contact the Claim Administrator, Wilson-McShane Corporation, at 952-854-0795 or toll-free at 1-800-535-6373. They will provide you the required application form and further information regarding the application process. The application will require that you provide the letter from your attending Physician containing the required details noted above. The Claim Administrator will review the application and advise you if the request is approved or denied.

If you are approved for this benefit, you will be required to provide itemized receipts for any qualifying lodging expenses. Non-itemized receipts will not be accepted.

PRESCRIPTION DRUG BENEFIT

Prescription Drug Card Program

The Plan provides a Prescription Drug Benefit that is designed to pay a portion of the cost of brand name and generic prescription drugs. The Prescription Drug Benefit is not subject to the Plan deductible or annual out-of-pocket maximum provisions. Certain drugs, such as lifestyle and cosmetic drugs are not covered. Drugs prescribed for the treatment of acne are covered.

Prescription Drug Card From Another Plan

If you or your Dependents use a prescription drug card from another plan, the Plan will reimburse 100% of the copayment you are required to make when using that card. Send your receipt to the Plan Administrator for reimbursement.

Retail Prescription Drug Card Program

A retail prescription drug card program is available which allows you to obtain your prescriptions by paying only the applicable coinsurance amount at participating network retail pharmacies and the mail service pharmacy. In order to participate in the retail prescription drug card program, you are required to show your Sheet Metal #10 Benefit Fund identification (ID) card to the pharmacist each time you purchase prescriptions. The amount of coinsurance that you will be required to pay at the point of service when you use a network pharmacy is as follows:

<i>Brand Name Drugs:</i>	20% of the cost of the prescription drug
<i>Generic Drugs:</i>	10% of the cost of the prescription drug

Certain pharmacies are able to dispense 90-day prescriptions for maintenance drugs. This 90 day Retail program helps the Participant and the Plan save money through discounted pricing and no dispensing fees. You can contact Prime Therapeutics for a list of these participating pharmacies at: www.myprime.com or call 1-800-509-0545.

Out-of-Network Retail Service Program

A retail service prescription drug program is available if you go to an out-of-network pharmacy. If you go to an out-of-network pharmacy, however, you must pay the entire retail cost for the prescription, regardless of whether you show your ID card or not. You must then submit your receipt to the Plan Administrator for reimbursement, and the Plan pays 80% of drug costs.

Mail Service Prescription Drug Program

A mail service prescription drug program is available for long-term prescriptions (drugs you take regularly and expect to take for an extended period). The Plan pays 80% for a 90-day supply at the time of purchase, after you have satisfied the medical deductible.

Over-the-Counter Medications

The Plan pays 90% of drug costs for certain over-the-counter (OTC) drugs such as proton pump inhibitors and non-sedating antihistamines. In order for these medications to be covered by the Plan, you must either

PRESCRIPTION DRUG BENEFIT

ask your pharmacist to contact your doctor to change your existing prescription to an OTC drug, or you must get a prescription from your doctor for the OTC drug. You must also present your Sheet Metal #10 Benefit Fund ID card at the pharmacy when purchasing these OTC medications.

Specialty Drug Program

A Specialty Drug program is available, which covers 100% of drug costs, not subject to the deductible or out-of-pocket limits, as long as you use the Plan's designated Specialty Drug pharmacy. No benefits are available if you purchase the drugs elsewhere, however, specialty medications provided by a Hospital or clinic are covered under the Major Medical portion of the Plan. Call the Fund Office for a list of covered Specialty Drugs.

AllianceRx Walgreens Prime Manufacturer Copay Assistance Program

In addition to the above-noted Specialty Drug provisions, if you are currently prescribed, or in the future are prescribed one of the specific Specialty Drugs in the manufacturer copay assistance program further detailed below, there will be a separate procedure that will apply to filling your Specialty Drug prescription. The procedure will operate as follows:

- If you currently have a prescription for a Specialty Drug you will be contacted by AllianceRx Walgreens Prime (ARxWP) regarding this updated insurance benefit. ARxWP will provide you with the information you need to make use of the manufacturer copay coupon program including the use of manufacturer coupons issued to assist in payment for your prescription.
- In the future, if you receive a prescription for a specialty drug in the manufacturer copay assistance program, you must contact ARxWP to fill the prescription. ARxWP will provide you with the information you need to make use of the manufacturer copay coupon program including the use of manufacturer's coupons issued to assist in payment for your prescription.
- The Specialty Drugs *currently* included in this program are:
 - Afinitor, Aubagio, Avonex, Betaseron, Cimzia, Copaxone (20 mg), Copaxone (40 mg), Cosentyx, Enbrel, Forteo, Glatopa (generic), Gleevec, Harvoni, Humira, Ibrance, Orencia, Otezla, Plegridy, Rebif, Simponi, Sovaldi, Sprycel, Stelara, Tecfidera and Xeljanz.
 - Please note that the above-noted list is subject to change.
- You will not be able to go to your regular pharmacy to fill the prescription for the above-noted Specialty Drugs. If you go to your pharmacy, your pharmacy will direct you to contact ARxWP at 1-877-627-6337 to fill the Specialty Drug prescription.

If you have questions regarding the copay coupon program for Specialty Drugs, you can contact the Fund Office at 651-770-0991.

PRESCRIPTION DRUG BENEFIT

Compound Drugs

Compound drugs that contain bulk chemicals that are not FDA-approved will be excluded from coverage. Compound kits and pain patches are also excluded from coverage.

Step Therapy

The Plan has implemented a step therapy program applicable to certain prescription drugs. A step therapy program is designed specifically for patients with certain conditions that require taking medications regularly. This program uses a step approach to provide coverage for the clinically appropriate, more cost-effective medication, and then progresses to other more-costly therapy(s) if the initial medication does not provide the adequate therapeutic benefit. In step therapy, medications are grouped into categories:

- 1st Step – First Line Medications: These medications should be tried first. They are mostly generic medications, which have been proven safe, effective and affordable.
- 2nd Step – Second Line Medications: These are mostly higher costing brand name medications.

If the First Line medication does not provide you with the therapeutic benefit desired, your Physician may write a prescription for a Second Line medication. Generally, the usage and failure of a First Line medication is required before the Second Line medication will be covered.

To see a full listing of drugs in the step therapy program, log onto the website listed on the back of your Sheet Metal #10 Benefit Fund member ID card.

EMPLOYEE ASSISTANCE PROGRAM

The Employee Assistance Program is a confidential resource that helps address various kinds of personal concerns. The program offers consultation, support, information and planning, as well as referrals to professional resources in your community. Services include face-to-face counseling, telephone or other electronic consultations, and support and educational materials for issues such as:

- Marital conflicts
- Legal issues
- Financial issues
- Family and relationship concerns
- Alcohol and/or drug dependency
- Emotional and psychological issues
- Spiritual concerns
- Occupational/vocational issues and rehabilitation

The program is currently administered by TEAM Corporation (TEAM).

Several key points about this service:

- All counseling by TEAM has been prepaid by The Fund. However, when a referral is made to another care provider, the cost will be handled according to the rules of the Plan.
- Every consultation is confidential. No information will be given to either your employer or the Union unless you specifically request it.
- This counseling is available to you and your eligible Dependents.

TEAM offices are located throughout the Twin Cities and confidential assistance is available 24 hours a day by calling: 651-642-0182 or 1-800-634-7710.

If you live outside the Twin Cities Area, TEAM will arrange for either themselves or another provider in your area to assist you. Please call TEAM for further information.

SMOKING CESSATION BENEFIT

If you or your eligible dependents smoke and desire to quit, the Plan offers a quitting tobacco support program to help you quit for good. You can register by simply calling 1-888-662-BLUE (2583) and you will then have access to a phone-based wellness coach who will guide and support your efforts. In addition, the Plan will provide benefits for certain nicotine replacement therapy aids such as patches, gum, and lozenges; and for all FDA-approved oral prescription medications.

Nicotine Replacement Therapy Aids: Purchase over the counter nicotine therapy replacement quit aids and submit your receipts to Wilson-McShane Corporation for 100% reimbursement. Reimbursement is not subject to the Plan's annual deductible.

Oral Prescription Medications: Present your doctor's prescription for an oral prescription medication (such as Chantix) at the pharmacy and the Plan will pay for 80% of a name brand prescription drug and 90% for a generic prescription drug.

MATERNITY MANAGEMENT

Maternity management is a personalized telephone and mail-based prenatal support program for expectant mothers. Mothers who receive consistent prenatal care are more likely to have healthier babies. Specially trained registered nurses educate and work with you to help achieve a normal full-term delivery.

Program benefits:

- Pre-term birth rates and the incident of low-birth weights for babies are lower for mothers who participate in the maternity management program.
- All maternity expenses are covered at 100% after the Plan's deductible is met if you are enrolled.

To enroll, you must call BlueCross BlueShield anytime at 651-662-1818 or toll free 1-866-489-6948 between 8:00 a.m. to 4:30 p.m. (central time).

DOCTOR ON DEMAND

Doctor on Demand (DOD) is an online service available that allows a covered person to visit a doctor using a computer, smartphone or tablet, with a front-facing camera. Medical care is available on-demand at www.doctorondemand.com/bluecrossmn from 7:00 am-11:00 pm in all time zones, 365 days a year or by appointment 24-hours a day, 7 days a week. DOD provides access to online care (including prescriptions, when appropriate) by appointment or on-demand from board-certified physicians in 47 states (not available in Alaska, Arkansas, Louisiana). The Plan provides coverage for this benefit at 100%, but only for Doctors on Demand, and not for any other form of electronic doctor visit program. There is no coinsurance or copayment required.

The DOD app works with any smartphone, tablet or computer, with a front-facing camera. You can download the app from the App Store or Google Play, or access DOD via the website: DoctorOnDemand.com/bluecrossmn.

Once a Participant has connected, they will speak with a doctor and can discuss an array of medical conditions such as sinus or ear infections, pink eye, cold or flu symptoms, allergies, depression or anxiety, rashes, urinary tract infections, and other medical conditions.

GENERAL EXCLUSIONS AND LIMITATIONS

Benefits will not be paid under this Plan for the following:

1. Treatment or supplies that are not Medically Necessary.
2. Expenses that are above the covered annual or lifetime limits for the service.
3. Treatment or service not prescribed by a Physician.
4. Injury or sickness arising out of, or in the course of, any employment for wage or profit.
5. Treatment or service that is compensated for, or furnished by, local, state or federal government or any public agency, and that part of charges for any services or supplies that are provided or available from the local, state, or federal government (for example, Medicare) whether or not that payment is received.
6. Injury, sickness, or death resulting from war or any act of war, declared or undeclared.
7. Expenses incurred by you for injuries resulting from or sustained as a result of commission, or attempted commission by you, of an illegal act that the Plan Administrator determines in its sole discretion, on the advice of legal counsel, involves violence or the threat of violence to another person or in which a firearm, explosive, or other weapon likely to cause physical harm or death is used by you, unless the injury or illness is the result of domestic violence or the commission or attempted commission of an assault or felony is the direct result of an underlying health factor. The Plan Administrator's discretionary determination that this exclusion applies will not be affected by any subsequent official action or determination with respect to prosecution of the covered individual (including, without limitation, acquittal, or failure to prosecute) in connection with the acts involved.
8. Custodial care, including room and board and other institutional services, that are provided to an individual primarily to assist in activities of daily living, and where such care is not reasonably expected to cure the individual of any illness or injury.
9. Voluntary termination of pregnancy, except when the pregnancy is a life-threatening medical condition for the covered female Participant or eligible Dependent. Medical documentation verifying the life-threatening condition to the Participant or eligible Dependent is required. Complications resulting from a voluntary termination of pregnancy are also covered.
10. Experimental/Investigative services or supplies that do not meet accepted medical practice standards.
11. Medical expenses of a Dependent, other than a spouse, who is entitled to benefits as an eligible employee of a Contributing Employer under the Fund's Active Plan of Benefits.
12. Specialty Drugs, except those purchased through the Specialty Drug program unless provided directly by your Hospital or clinic during the course of your treatment. See page 39.
13. Lifestyle and cosmetic drugs are not covered, except drugs prescribed specifically for the treatment of acne, sex transformation, or erectile dysfunction. Erectile dysfunction drug coverage is limited to 15-unit doses per month per Participant. However, erectile drugs in low dose form taken on a daily basis, will not be subject to the above-noted 15-day limit.

GENERAL EXCLUSIONS AND LIMITATIONS

14. Services or supplies for which the individual is not required to make payment or would have no obligation to pay if he did not have this coverage.
15. Charges for failure to keep a scheduled visit or charges for completion of a claim form.
16. Equipment for personal hygiene, comfort or convenience including, but not limited, to air conditioners, humidifiers, physical fitness and exercise equipment, home traction units, tanning beds, water beds or purifiers, hot tubs, whirlpools, swimming pools, dehumidifiers, orthopedic mattresses, elevators, or stair lifts.
17. Experimental or Investigative drugs, drugs that may be dispensed without a prescription (such as aspirin), and over-the-counter products unless specifically included in the *Schedule of Benefits* or elsewhere in the Plan (e.g., insulin).
18. Nondurable medical supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including, but not limited to, bandages, hypodermic syringes (except as appropriate when required for delivery of the drug prescribed), diapers, support garments, except at the discretion of the Board of Trustees when Medically Necessary.
19. Attorney's fees relating to Workers Compensation or personal injury proceedings.
20. Hospital charges for confinement following the time the attending Physician approves discharge from the Hospital.
21. Eye exercise or vision training, but only when not medically necessary.
22. Artificial insemination, in vitro fertilization, gamete intra-fallopian transfer, or any other procedure that attempts to promote fertility. However, this exclusion does not include procedures for the medical treatment of infertility due to sickness, injury or bodily defect, except that artificial insemination, in vitro fertilization, gamete intra fallopian transfer or similar fertility promotion procedures or techniques will remain excluded from coverage even if part of this treatment.
23. Charges related to memberships in a health club, swimming programs, and physical fitness programs other than at a Hospital outpatient department.
24. Construction or a modification to a home, residence, or vehicle required because of an injury, illness or disability.
25. Vasectomy reversal or tubal ligation reversal.
26. Routine foot care, including but not limited to, trimming of toenails, removal of calluses, and preventive care.
27. Orthopedic shoes, except when attached to a brace and prescribed by a Physician.
28. Medical treatment from a Hospital or Physician that reimburses or waives the cost of transportation or provides other incentives for an individual to receive medical treatment, either within or outside the geographic jurisdiction of the Fund, if charges exceed the Reasonable and Customary charge for the treatment in the appropriate geographic area of the Plan. When determining the appropriate

GENERAL EXCLUSIONS AND LIMITATIONS

geographic area, the Trustees will consider the geographic area where the covered individual normally would have received this type of medical treatment.

29. Chelation therapy, except for any expense or charges for chelation therapy for acute arsenic, gold, mercury, or lead poisoning.
30. Claims that are submitted 24 months or later after the service was performed.
31. Charges in excess of the Reasonable and Customary charge.
32. Recreational therapy.
33. Marriage counseling, except as provided by the Employee Assistance Program at no additional charge.
34. Acupuncture.
35. Subject to the Bariatric Surgery Benefit, medical or surgical treatment for weight reduction or obesity, including morbid or exogenous obesity. This exclusion includes, but is not limited to, dietary programs and surgical interventions. Examples of excluded procedures or treatments are gastric bypass, Roux-en-Y procedure, vertical banded gastroplasty, loop gastric bypass, simply gastroplasty (more commonly known as stomach stapling), duodenal switch operation, biliopancreatic bypass (Scopinaro procedure), mini gastric bypass, implantable gastric stimulators, and other weight loss surgeries. Also excluded from coverage is treatment required because of or arising from, complications from a treatment or condition excluded by this paragraph.
36. Services from a Physician who does not meet the Plan's definition of Physician.
37. Dental services or surgery, except as provided under the Major Medical provision of this SPD.
38. Charges relating to surrogate pregnancies, including, but not limited to, charges relating to actual or attempted impregnation or fertilization involving a Participant, a Dependent, or a surrogate as a donor or recipient, extra-uterine conception, or the pregnancy of a surrogate mother. This exclusion applies whether or not the surrogate mother has acted pursuant to a contract between the parties and whether or not the surrogate mother is paid for her service.
39. All medication, devices or other methods used for smoking cessation except as covered under the Smoking Cessation Benefit as detailed on Page 42.
40. Any loss, expense or charge:
 - a. For which a third party may be liable; and
 - b. For which either:
 - i. A recovery subject to the Plan's subrogation and reimbursement rights has been received (whether before or after the submission of or payment of claims by the Plan); or
 - ii. The Plan deems it likely that recovery will be received.

GENERAL EXCLUSIONS AND LIMITATIONS

At the discretion of the Trustees, losses, expenses and charges excluded by this paragraph may be paid subject to the Plan's right of subrogation and reimbursement. The term "Third Party" as used in this section includes any individual, insurer, entity, or federal, state or local government agency, who is or may be in any way legally obligated to reimburse, compensate or pay for an individual's loss, damages, injuries or claims relating in any way to the injury, occurrence, condition or circumstance giving rise to the Plan's provision of medical, dental or disability benefits, including but not limited to, insurers providing liability, medical expense, wage loss, uninsured motorist or under-insured motorist coverages.

41. Any loss, expense, or charge incurred as the result of any injury, occurrence, conditions, or circumstance for which the injured individual:
 - a. Has the right to recover payment from a Third Party (at the discretion of the Trustees, losses, expenses and charges excluded by this paragraph may be paid subject to the Plan's right of subrogation and reimbursement);
 - b. Has recovered from a Third Party; or
 - c. Has not submitted a claim for such loss, expense, or charge to the Plan prior to resolution of the Third Party claim.
42. Inpatient out-of-network benefits (The Plan continues to cover Emergency Medical Conditions)
43. Compound drugs including those that contain bulk chemicals that are not FDA approved, compound kits and pain patches.

BENEFIT CLAIMS AND APPEALS

This section describes the procedures for filing claims for benefits from the Fund. It also describes the procedure for you to follow if your claim is denied, in whole or in part, and you wish to appeal the decision.

How to File A Claim

A claim for benefits is a request for Fund benefits made in accordance with the Fund's reasonable claims procedures. To file a claim for benefits offered under this Fund, you must submit a completed claim form. Simple inquiries or phone calls about the Fund's provisions that are unrelated to any specific benefit claim will not be treated as a claim for benefits. In addition, a request for prior approval of a benefit that does not require prior approval by the Fund is not a claim for benefits.

A claim form may be obtained from the Fund's third-party administrator (presently Wilson-McShane Corporation) by calling 952-854-0795 or 1-800-535-6373. If you use the services of a network provider, the provider will generally file your claims for you. The following information must be completed for your request for benefits to be a claim, and for the Claim Administrator to be able to decide your claim:

- Retiree name;
- Patient name;
- Patient date of birth;
- Social Security number of Retiree; or ID# listed on your Sheet Metal #10 Benefit Fund ID card;
- Date of service;
- Current procedural terminology and the International Classification of Diseases codes related to the claim;
- Billed charge;
- Number of units (for anesthesia and certain other claims);
- Federal taxpayer identification number (TIN) of the provider;
- Billing name and address; and
- If treatment is due to accident, accident details.

When Claims Must Be Filed

You must file your claim for benefits as soon as possible following the date you incurred the charges. If you fail to file your claim within a reasonable time, it will not invalidate or reduce your claim if it was not reasonably possible for you to file the claim within a reasonable time. However, in that case, you must submit your claim as soon as reasonably possible, and in no event, later than 24 months from the date you incurred the charges. The Board of Trustees will determine whether you have proved good cause for filing a late claim.

BENEFIT CLAIMS AND APPEALS

Where Claims Must Be Filed

Blue Cross claims should be submitted to Blue Cross as shown on your Sheet Metal #10 Benefit Fund ID card. Your claim will be considered to have been filed as soon as it is received by the Claims Administrator.

You should file your claims with the Fund at the following address:

Sheet Metal #10 Benefit Fund
PO Box 9474
Minneapolis, Minnesota 55440-9474

Facility of Payment of Claims

Accrued claims unpaid at the eligible retiree's death may, at the option of the Trustees, be paid either to the eligible retiree's beneficiary or to the eligible retiree's estate.

If any claim is payable to the estate of the eligible retiree or to a beneficiary who is a minor or otherwise not competent to give a valid release, the Trustees may pay the claim up to an amount not exceeding \$5,000.00 to any relative by blood or connection by marriage of the eligible retiree or beneficiary who is deemed by the Trustees to be equitably entitled. Any payment made by the Trustees in good faith according to this provision will fully discharge the Trustees to the extent of the payment.

Any claims for Hospital, nursing, medical, or surgical service may, at the Trustees' option, be paid directly to the Hospital or person rendering such services.

Physical Examinations and Autopsy

The Board of Trustees, at its own expense, has the right to examine any individual whose injury or illness is the basis of a claim and to request an autopsy to be performed in case of death where it is not forbidden by law.

Discretionary Authority of Fund Administrator

In carrying out their respective responsibilities under the Fund, the administrator and other Fund fiduciaries and individuals to whom responsibility for the administration of the Fund has been delegated, have discretionary authority to interpret the terms of the Fund and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to benefits in accordance with the terms of the Fund. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Authorized Representatives

An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. You

BENEFIT CLAIMS AND APPEALS

can obtain a form from the Fund's third-party administrator to designate an authorized representative. The Fund may request additional information to verify that this person is authorized to act on your behalf.

Assignment of Benefits

You do not have the right to anticipate, alienate, sell, transfer, pledge, assign, or otherwise encumber any interest in benefits to which you may become entitled under the Fund. The Trustees may, however, honor your assignment of benefits to the provider of covered services.

Post-Service Medical Claims

When you file a post-service medical claim, you have already received the services in your claim.

The following procedures apply to post-service medical claims:

- Obtain a claim form (or a claim may be filed for you by a PPO or other network provider).
- Complete your (the Retiree's) portion of the claim form.
- Have your Physician complete the Attending Physician's Statement section of the claim form, submit a completed HCFA health insurance claim form, or submit an HIPAA-compliant electronic claims submission.
- Attach all itemized Hospital bills or Physician's statements that describe the services rendered.

To speed the processing of your claim, check the claim form to be certain that all applicable portions of the form are completed and that you have submitted all itemized bills. If the claim forms have to be returned to you for information, delays in payment will result.

You do not have to submit an additional claim form if your bills are for a continuing disability and you have filed a claim within the past Calendar Year period. Mail any further bills or statements for any medical or Hospital services covered by the Fund to the Fund's third-party administrator as soon as you receive them.

Ordinarily, you will be notified of the decision on your Post-Service medical claim within 30 days from The Fund's receipt of the claim. This period may be extended one time by the Fund for up to 15 days if the extension is necessary due to matters beyond the control of the Fund. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the Fund expects to render a decision.

If an extension is needed because the Fund needs additional information from you, the extension notice will specify the information needed. In that case, you will have 45 days from receipt of the notification to supply the additional information. If you do not provide the information within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). The Fund then has 15 days to make a decision on a Post-Service Medical Claim and notify you of the determination.

BENEFIT CLAIMS AND APPEALS

Notice of Denial of Claim or Adverse Benefit Determination

The Trustees must provide you with a notice of their initial determination about your claim within certain timeframes after they receive your claim. The notice must provide you with the following information:

- The specific reason or reasons for the denial of benefits or other adverse benefit determination;
- A specific reference to the pertinent provisions of the Fund upon which the decision is based;
- A description of any additional material or information that is needed to process your claim and an explanation of why the information is needed;
- A copy of the Fund's review procedures and time periods to appeal your claim, plus a statement that you may bring a lawsuit under ERISA following the review of your claim;
- A copy of any internal rule, guideline, protocol or similar criteria that was relied on, or a statement that a copy is available to you at no cost upon request;
- A copy of the scientific or clinical judgment or statement that it is available to you at no cost upon request for medical claims that are denied due to:
 - Medical Necessity;
 - Experimental treatment; or
 - Similar exclusion or limit.

Your Right to Request a Review of a Denied Claim

You have the right to a full and fair review by the Board of Trustees if your claim for benefits is denied by the Fund. You must make your request to the Board within 180 days after you receive notice of denial. Your application for review must be in writing, and it must include the specific reasons you feel denial was improper. You may submit any document you feel appropriate, as well as submitting your written issues and comments.

You have the right to review documents relevant to your claim. A document, record, or other information is relevant if:

- It was relied upon by the Fund in making the decision;
- It was submitted, considered, or generated in the course of making the benefit determination (regardless of whether it was relied upon);
- It demonstrates compliance with the Fund's administrative processes for ensuring consistent decision-making; or
- It constitutes a statement of Fund policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Fund on your claim, without regard to whether their advice was relied upon in deciding your claim.

BENEFIT CLAIMS AND APPEALS

A different person will review your claim than the one who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made based on the record, including such additional documents and comments that may be submitted by you.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary, or was Investigative or Experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

Second Level Review – Appeal to the Board of Trustees

If you still disagree with the determination of your claim, you may make an appeal to the Board of Trustees. Ordinarily, decisions on appeals involving Post-Service Medical Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your appeal. However, if your appeal is received within 30 days of the next regularly scheduled meeting, your appeal will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your appeal may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on your claim has been reached by the Board of Trustees, you will be notified of the decision as soon as possible, but no later than five days after the decision has been reached.

When appealing a claim, you have certain rights under federal law. These include:

- You will have the opportunity to submit written comments, documents, records, and other information relating to the claim.
- You will be provided upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.
- The review by the Plan will take into account all comments, documents, records, and other information submitted by you related to your claim, whether or not the information was submitted or considered in the initial benefit determination.
- If your appeal is for disability benefits, the Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim and further, will provide you with such rational as soon as possible and sufficiently in advance of the date of review of the denial by the Plan, so as to give you a reasonable opportunity to respond prior to that date.

BENEFIT CLAIMS AND APPEALS

Notice of Decision on Appeal

The decision on any appeal of your claim will be given to you in writing. The notice of a denial of a claim on appeal will state:

- The specific reason(s) for the determination.
- Reference to the specific Fund provision(s) on which the determination is based.
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge.
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

If an internal rule, guideline, or protocol was relied upon by the Fund, you will receive either a copy of the rule or a statement that it is available upon request at no charge. If the determination was based on Medical Necessity, or because the treatment was Experimental or Investigative, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of The Fund to your claim, or a statement that it is available upon request at no charge.

Legal Actions

You may not start a lawsuit to obtain benefits until after you have requested an appeal to the Board of Trustees and a final decision has been reached, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. Any lawsuit based on the denial of your appeal by the Fund's Board of Trustees is governed by the applicable statute of limitations.

MEDICAL DATA PRIVACY POLICY

Under the Health Insurance Portability and Accountability Act (HIPAA), the Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to tell you about:

- The Plan's uses and disclosures of Protected Health Information ("PHI");
- Your privacy rights with respect to your PHI;
- The Plan's duties with respect to your PHI;
- Your right to file a complaint with the Plan and the Secretary of the U.S. Department of Health and Human Services; and
- The person or office to contact for further information about the Plan's privacy practices.

The Plan's Use and Disclosure of PHI

The Plan will use Protected Health Information ("PHI") to the extent of, and according to, the uses and disclosures allowed by the Medical Data Privacy Regulations ("Privacy Regulations") adopted under HIPAA, including for purposes related to *Health Care Treatment, Payment, and Health Care Operations*.

The Plan will enter into agreements with other entities known as "Business Associates" to perform some of these functions on behalf of the Plan. Each Business Associate will be allowed to use and disclose only the minimum amount of PHI needed to perform the Business Associate's duties on behalf of the Plan. The Plan's agreements with its Business Associates will also meet the other requirements of the Privacy Regulations.

Use of PHI for Treatment Purposes

Treatment includes the activities relating to providing, coordinating or managing healthcare and related services. It also includes, but is not limited to, consultations and referrals between one or more of your providers. As a health plan, the Plan is generally not involved in treatment situations but may, from time-to-time, release PHI to assist providers in your treatment.

Use of PHI for Payment and Health Care Operations

Payment includes the Plan's activities to obtain premiums, contributions, self-payments, and other payments to determine or fulfill the Plan's responsibility for coverage and providing benefits under the Plan. It also includes the Plan obtaining reimbursement or providing reimbursement for providing health care that has been provided. These activities include, but are not limited to, the following:

- Determining eligibility or coverage under the Plan;
- Adjudicating claims for benefits (including claim appeals and other benefit payment disputes);
- Subrogation;
- Coordination of benefits;
- Establishing self-payments by persons covered under the Plan;
- Billing and collection activities;
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes, and responding to covered persons' inquiries about payments;
- Obtaining payment under stop-loss or similar reinsurance;

MEDICAL DATA PRIVACY

- Reviewing whether claims are payable under the Plan, including whether they are Medically Necessary, Reasonable and Customary, or otherwise payable;
- Reviewing coverage under the Plan, appropriateness of care, or justification of charges;
- Utilization review, including precertification, preauthorization, concurrent review, and retrospective reviews;
- Disclosing to consumer reporting agencies certain information related to collecting contributions or reimbursement (the information that may be released is: name and address, date of birth, Social Security number, payment history, account number, and name and address of the provider and/or health plan); and
- Reimbursement to the Plan.

Healthcare operations can include any of the following activities. While the Plan does not currently use or release PHI for all of these activities, it may do so in the future to perform health care operations of the Plan:

- Conducting quality assessment and improvement activities, including outcomes, evaluation, and development of clinical guidelines as long as general knowledge is not the primary purpose of these studies; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;
- Reviewing the competency or qualifications of health care professionals; evaluating provider performance; accreditation, certification, licensing, or credentialing activities;
- Underwriting, premium rating and other activities relating to creating, renewing, or replacing a health insurance contract (or reinsurance) or health benefits under the Plan;
- Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
- Planning and development, such as conducting cost-management and planning-related analyses relating to managing and operating the Plan (including formulary development and administration, development, or improvement of methods of payment or coverage policies); and
- Management and general administrative activities of the Plan, including but not limited to:
 - Managing activities related to implementing and complying with the Privacy Regulations;
 - Resolving claim appeals and other internal grievances;
 - Merging or consolidating the Plan with another plan, including related due diligence; and
 - As permitted under the Privacy Regulations, creating de-identified health information or a limited data set.

MEDICAL DATA PRIVACY

Other Uses and Disclosures of PHI

The Privacy Regulations permit certain other uses and disclosures of your PHI. These include, for example, releasing PHI to personal representatives of deceased covered persons, releasing PHI for public health activities, releasing PHI for court proceedings, and releasing PHI for law enforcement and similar purposes. If the Plan releases PHI in any of these other permitted situations, it will do so according to the requirements of the Privacy Regulations.

The Privacy Regulations also permit the Plan to release PHI if it receives a valid authorization from you. If the Plan receives a valid authorization, the Plan will disclose PHI to the person or organization you authorize to receive the information. This may include, for example, releasing information to your spouse, to the pension plan, other retirement plans, vacation plan, or similar plan for the purposes related to administering those plans.

Release of PHI to the Board of Trustees

The Plan will disclose PHI to the Board of Trustees, which is considered the Plan Sponsor under the Privacy Regulations. The Plan has received a certificate from the Board of Trustees that the Plan documents, including this Summary Plan Description, have been amended to incorporate the following provisions.

The Board of Trustees will receive and use PHI only for the Plan administration functions that the Trustees perform for the Plan. In addition, the Trustees will:

- Not use or further disclose PHI other than as permitted or required by the Summary Plan Description or as required by law.
- Ensure that any agents (such as Union Business Agents or the Trustees' staffs), including subcontractors, to whom the Board of Trustees provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Board of Trustees with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by the person who is the subject of the PHI;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the person who is the subject of the information;
- Report to the Plan any PHI use or disclosure that is inconsistent with the allowed uses or disclosures of which it becomes aware;
- Make PHI available to a person who is the subject of the information according to the Privacy Regulation's requirements;
- Make PHI available for amendment and incorporate any amendments to PHI according to the requirements of the Privacy Regulations;
- Make available the PHI required to provide an accounting of disclosures;
- Make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for the purposes of determining the Plan's compliance with the Privacy Regulations; and
- If feasible, return or destroy all PHI received from the Plan that the Trustees maintain in any form, and retain no copies of the PHI when no longer needed for the purpose for

MEDICAL DATA PRIVACY

which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

Trustee Access to PHI for Plan Administration Functions

As required under the Privacy Regulations, the Plan will give access to PHI only to the following persons:

- The Board of Trustees (including alternate Trustees). The Plan will release PHI to the Trustees, and the Trustees will be able to use PHI, for purposes of hearing and determining claim appeals; making other determinations concerning claims payments; assisting covered persons with eligibility and benefit issues; Plan benefit design; amending, modifying, and terminating the Plan; and Plan management issues.
- The Trustees' agents, such as Union Business Agents, and the Trustees' staffs, only to the extent reasonable to assist the Trustees in fulfilling their duties consistent with the above uses and disclosures of PHI.

Noncompliance Issues

If the persons described above do not comply with this Summary Plan Description, the Board of Trustees will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

Plan's Privacy Officer and Contact Person

As required by the Privacy Regulations, the Plan has named a Privacy Officer to oversee the Plan's compliance with the Privacy Regulations. The Plan has also named a Contact Person to help answer your questions concerning the Privacy Regulations and your PHI. You can also call the Contact Person if you have any complaints concerning the use or disclosure of your PHI. If you have any questions or complaints concerning your PHI, please contact the Plan Administrator and ask to speak with the Plan's Contact Person.

COORDINATION WITH OTHER BENEFITS

This Plan has been designed to help you meet the cost of disease or injury. Because it is not intended that you receive greater benefits than the actual medical expenses incurred, the benefits under this Plan will be coordinated with the benefits from other plans. Benefits payable by this Plan and any other plans will not exceed 100% of allowable expenses. In no event will payment under this Plan exceed the amount that would have been allowed if no other plan were involved.

Allowable expenses are any Medically Necessary, Reasonable and Customary expenses that would be covered under any of the other plans, but not any expenses that are listed in the General Exclusions and Limitations.

Other plan means any plan providing benefits or services for medical, dental, or vision care or treatment, when benefits or services are provided by:

- Group insurance or any other arrangement of coverage for individuals in a group whether on an insured or self-funded basis;
- Group Blue Cross or group Blue Shield coverage or other prepayment coverage;
- Any coverage under Labor-Management Trustee Plans, Union Welfare Plans, Employer Organization Plans, Employee Benefits Organization Plans, or any other arrangement of benefits for individuals of a group;
- Any coverage under governmental programs, and any coverage required or provided by any statute;
- Any no-fault automobile insurance coverage provided under the laws of the State of Minnesota or other states; or
- Any award of damages, whether by settlement, jury verdict, or Court Order, paid by any third party for injuries.
- Dependents' benefits payable under this Plan when a spouse is covered both as an eligible employee and as an eligible Dependent and when a child is covered as a Dependent of more than one eligible employee.

Effect on Benefits

If you and/or your Dependent (s) are covered by another plan or plans, the benefits under this Plan and the other plans will be coordinated. This means that one plan pays its full benefits first, then the other plan pays as follows:

- The primary plan (the plan that pays benefits first) pays the benefits it would pay if there were no coordination of benefits rule.
- The secondary plan (the plan that pays benefits after the primary plan) will limit the benefits it pays so that the sum of the total benefits paid does not exceed 100% of allowable expenses.

Order of Benefit Determination

To determine the amount of benefits payable under this Plan and the amounts to be paid by other plans, the first of the following rules that apply will determine the order of benefits payable:

COORDINATION WITH OTHER BENEFITS

- A plan without coordination of benefits rules will determine benefits before a plan that contains coordination of benefits rules.
- A plan that covers the claimant as an employee will determine benefits before a plan that covers the person as other than an employee.
- The Plan covering a person as a laid-off or retired employee, or as a Dependent of a laid-off or retired employee, will be secondary to the benefits of any other plan covering the person. This rule does not apply if the other plan does not have this rule.
- If an individual is covered as an employee under two plans, the Plan that has covered him or her longer is primary, and pays benefits first. However, when the individual is eligible under one plan as a currently working employee and under the other by bank hours or some other reserve accumulation system that continues eligibility, the Plan that covers the individual as a currently working employee will be primary and pay benefits first.
- For claims on behalf of Dependent children, the Plan that covers the parent whose birthday (month and day) falls earlier in the Calendar Year will determine benefits before the Plan of the parent whose birthday falls later in the year. If the parents have the same birthday, the Plan covering the parent for the longer period will determine benefits first.
- If one plan uses the gender rule and the other plan coordinates benefits using the birthday rule, the gender rule plan will determine the order of benefit payment. Under the gender rule, the Plan of the male Retiree determines benefits for Dependents before the Plan of the female employee.
- For Dependent children of separated or divorced parents:
 - Where there is a court decree that establishes financial responsibility for medical expenses, the Plan covering the parent who has the financial responsibility will determine benefits first.
 - If there is no court decree, the Plan that covers the custodial parent will determine benefits first.
 - If there is no court decree and the parent with custody has remarried, the order of benefits will be:
 - The Plan of the custodial parent will determine benefits first;
 - The Plan of the stepparent with custody will determine benefits next; and
 - The Plan of the non-custodial parent will determine benefits last.

COORDINATION WITH MEDICARE

Medicare (Title XVIII of the Social Security Act, as amended) provides a program of health insurance. The benefits payable under this Plan will be coordinated with the benefits payable under Medicare.

For eligible Retirees, Age 65 and older, Medicare will be primary. This means that you will first be reimbursed under Medicare and, if there are any expenses remaining unpaid, you will then be reimbursed for those expenses for which benefits are payable under this Plan. This also applies to a spouse of Retiree if both the Retiree and spouse are Age 65 or older.

Once you retire and are entitled to Medicare, medical benefits will be coordinated with Medicare whether or not you actually enroll for such coverage. **This means that if you are eligible for Medicare but not enrolled in Part A or Part B, benefits provided by the Plan will be reduced by the amount Medicare would have paid if you had enrolled.** The Plan's prescription drug coverage is actuarially equivalent to Medicare Part D, prescription drug coverage. If you enroll for Medicare Part D, you will lose prescription drug benefits under this Plan. **The Trustees recommend that you do not enroll in Medicare Part D.**

It is very important that you enroll in both Parts A and B when eligible. If you are not enrolled in Medicare, you should immediately contact your local Social Security Office. If you have further questions, call the Benefit Fund Office for assistance.

The Medicare coordination of benefits rules apply before any other coordination of benefits rules of this Plan.

Order of Benefit Determination:

For You:

This Plan has primary responsibility for your claims, if all of the following apply:

- You are at least Age 65;
- You are eligible for Medicare Part A solely because of age; and
- You are actively employed by an Employer that pays all or part of the required contributions for eligibility.

This Plan has secondary responsibility for your claims when you are eligible for Medicare Part A because of age and you are not actively employed by a Contributing Employer who pays all or part of the required contributions for eligibility.

For Your Dependent Spouse:

This Plan has primary responsibility for your Dependent spouse's claims if all of the following apply:

- Your spouse is at least Age 65;
- Your spouse is eligible for Medicare Part A solely because of age; and
- You are actively employed by an Employer that pays all or part of the required contributions for the eligibility.

COORDINATION WITH MEDICARE

For a Participant with End-Stage Renal Disease: This Plan has secondary responsibility for the claims of an eligible person who is eligible for primary Medicare Benefits because of end-stage renal disease. This Plan has primary responsibility for such claims during the waiting period if the person is also eligible for Medicare due to age.

Effect on Benefits

If this Plan is primary, this Plan will pay benefits without considering the other plans.

If this Plan is secondary, Medicare Benefits are determined or paid first, then benefits under this Plan are paid.

If Medicare is primary **and** if you have SMW+ coverage, then the order of payment is:

1. Medicare pays first.
2. Submit your Medicare Explanation of Benefits (EOB) to SMW+ for their payment.
3. Submit the Medicare and SMW+ EOB's to the Fund's third-party administrator for any final payments.

The combined Medicare, SMW+ and Plan benefits will not exceed 100% of the expense incurred.

SUBROGATION

The Plan has a first priority subrogation and reimbursement right if it provides benefits resulting from or related to an injury, occurrence or condition for which the subrogee has a right of redress against any third party. For purposes of this Subrogation and Reimbursement section, subrogee means the participant, employee, dependent, beneficiary, representative (including a trustee in a wrongful death action), an administrator of an estate or any other person asserting a claim related to the injury, claim, action or occurrence under this section.

What does first priority right of subrogation and reimbursement mean? It means that if the Plan pays benefits which are, in any way, compensated by a third-party, such as an insurance company, the subrogee agrees that when a recovery is made from that third party, the Plan is fully reimbursed out of that recovery for the benefits the Plan previously paid. If the subrogee does not agree to the Plan's subrogation and reimbursement rules, benefits will not be paid.

For example, the subrogation and reimbursement right may apply if a subrogee is injured at work, in an automobile accident, at a home or business, in an assault, as a result of medical or other negligence or in any other way for which a third-party has or may have responsibility. If a recovery is obtained from a third-party, such as an insurance company, the Plan will be paid first and to the full extent of the benefits it paid. The subrogee receives payment only after the Plan is fully reimbursed.

The rights of subrogation and reimbursement are incorporated into this Plan for the benefit of each subrogee in recognition of the fact that the value of benefits provided to each employee or dependent will be maintained and enhanced by enforcement of these rights.

Subrogation and Reimbursement – Rules for the Plan

The following rules apply to the Plan's right of subrogation and reimbursement:

Subrogation and Reimbursement Rights in Return for Benefits: In return for the receipt of benefits from the Plan, the subrogee agrees that the Plan has the subrogation and reimbursement rights as described in this Subrogation and Reimbursement section. Further, the subrogee and their attorney will sign a Subrogation Agreement with the Plan acknowledging the Plan's subrogation and reimbursement rights prior to payment, or further payment, of benefits. Benefits will not be paid if the subrogee and/or their attorney refuses to sign the Subrogation Agreement. The Plan's subrogation and reimbursement rights to benefits paid prior to Plan notice of a subrogation and reimbursement right are not impacted if the subrogee and (if represented) their attorney refuses to sign the Subrogation Agreement. Should the subrogee and/or their attorney fail to sign the required Subrogation Agreement, the Plan will take any and all action necessary to protect its subrogation and reimbursement rights including denying the payment of benefits, offsetting any future benefits payable under the Plan, recouping any benefits previously paid, suspending and/or terminating coverage under the Plan.

Plan Granted Constructive Trust or Equitable Lien: The Plan's subrogation and reimbursement rights grant the Plan an equitable lien on the proceeds of any recovery obtained by the subrogee from a third-party, whether by settlement, judgment or otherwise and in consideration for the payment of benefits, the aforementioned individual(s) agree to the same. When a recovery is obtained, the recovery proceeds are

SUBROGATION

held in trust for the Plan. The Plan then imposes a constructive trust or equitable lien on the recovery proceeds and is paid to the full extent of its equitable subrogation and reimbursement rights. If the subrogee fails to hold the recovery proceeds in trust or in any other way prejudices or adversely impacts the Plan's subrogation and reimbursement rights, the Plan reserves the right to, among other things, and at the discretion of the Trustees, pursue all available equitable remedies, pursue all available legal remedies, offset any benefits payable under the Plan, recoup any benefits previously paid, suspend all benefits available under the Plan, deny all claims related to the incident in which a recovery was received in addition to non-related claims submitted by the subrogee, or terminate coverage of the subrogee or subrogees.

Subrogee Constructive Trust and/or Equitable Lien Duties: The subrogee is required to use his or her best efforts to preserve the Plan's right of subrogation and reimbursement. This will include, but not be limited to, the subrogee's causing of the Plan's subrogation or reimbursement interest to be paid to the Plan, advising their legal counsel to segregate the Plan's subrogation or reimbursement interest to be held in such legal counsel's trust account until the Plan's interest is agreed to or completely adjudicated, and not allowing any other disbursement from any settlement or judgment proceeds to subrogee, subrogee's attorney, or any other third-party, prior to complete disbursement to the Plan. Should subrogee fail to use their best efforts to preserve the Plan's right of subrogation and reimbursement, including but not limited to, the actions set-forth in the paragraph above as well as the entirety of these subrogation provisions and the terms of the Plan as a whole, subrogee's coverage under the Plan will terminate until such time as the Plan is made whole, including the reimbursement of all interest, attorney's fees and costs reasonably incurred. Only upon the Plan's being made whole may the subrogee make application to the Board of Trustees of the Plan for reinstatement of their coverage.

Plan Paid First: Amounts recovered or recoverable by or on the subrogee's behalf are paid to the Plan first, to the full extent of its subrogation and reimbursement rights, and the remaining balance, if any, to the subrogee. The Plan's subrogation and reimbursement right comes first even if the subrogee is not paid for all of their claims for damages. If the Plan's subrogation and reimbursement rights are not fully satisfied directly by a third-party, the Plan's right to reimbursement may be enforced to the full extent of any recovery that the subrogee may have received or may be entitled to receive from the third-party.

Right to Take Action: The Plan's right of subrogation and reimbursement is an equitable one and applies to all categories of benefits paid by the Plan. The Plan can bring an action (including in the subrogee's name) for, breach of contract, specific performance, injunction or any other equitable action necessary to protect its rights in the cause of action, right of recovery or recovery by a subrogee. The Plan will commence any action it deems appropriate against a subrogee, an attorney or any third-party to protect its subrogation and reimbursement rights. The subrogation and reimbursement right applies to claims of eligible Dependents covered by the Plan regardless of whether such Dependent is legally obligated for expenses of treatment.

Applies to All Rights of Recovery or Causes of Action: The Plan's subrogation and reimbursement rights apply to any and all rights of recovery or causes of action the subrogee has or may have against any third-party, regardless of whether such person or entity has the right, legal or otherwise, to recover the medical expenses paid by the Plan.

SUBROGATION

No Assignment: The subrogee cannot assign any rights or causes of action they may have against a third-party to recover medical expenses without the express written consent of the Plan.

Full Cooperation: The subrogee will cooperate fully with the Plan and do nothing to prejudice or adversely affect the Plan's subrogation and reimbursement rights. Benefits will be denied or recouped if the subrogee does not cooperate with the Plan. This includes, but is not limited to, responding to any Plan request for information and updates.

Notification to the Plan: The subrogee must promptly advise the Plan Administrator, in writing, of any claim being made against any person or entity to pay the subrogee for their injuries, sickness, or death. Further, the subrogee must periodically update the Plan regarding the claim and notify the Plan of a settlement prior to reaching a compromise of their claims. The subrogee must promptly notify the Plan Administrator, in writing, with the name, address, and telephone number of their attorney in the event a claim is pursued.

Third Party: Third party includes, but is not limited to, all individuals, entities, federal, state or local governments, and insurers (including, but not limited to, liability, medical expense, wage loss, workers compensation, premises liability, no-fault, uninsured or underinsured motorist insurers), who reimburse, compensate, pay or are liable for a subrogee's losses, damages, injuries or claims relating in any way to the injury, occurrence, conditions or circumstances leading to the Plan's payment of benefits. This right of subrogation and reimbursement exists regardless of whether the policy of insurance is owned by the subrogee.

Apportionment, Comparative Fault, Contributory Negligence, Make-Whole, and Common-Fund Doctrines Do Not Apply: The Plan's subrogation and reimbursement rights include all portions of the subrogee's claims regardless of any allocation or apportionment that purports to dispose of any portion of the claims not otherwise subject to subrogation, including, but not limited to, any apportionment for pain and suffering, wage loss, partial or total disability, or to a spouse for loss of consortium. The Plan's subrogation and reimbursement rights are not affected, reduced, or eliminated by comparative fault, contributory negligence, the make-whole and common-fund doctrines, or any other equitable defenses.

Attorney's Fees: The Plan will not be responsible for any attorney's fees or costs incurred by the subrogee in any legal proceeding or claim for recovery, unless prior to incurring such fees or costs, the Trustees agree in writing to pay all or some portion of attorney's fees or costs.

Course and Scope of Employment: If the Plan has paid benefits for any injury which may have arisen out of and in the course and scope of employment, the Plan's right of subrogation and reimbursement will apply to all awards or settlements received by the subrogee regardless of how the award or settlement is characterized and regardless of whether the Plan has intervened in the action. If attorney's fees are awarded to the subrogee's attorney from the Plan's recovery, the subrogee will reimburse the Plan for the attorney's fees.

IMPORTANT INFORMATION ABOUT THE FUND

The following information is provided to help you identify this Fund and the people who are involved in its operation, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Fund Name

Sheet Metal #10 Benefit Fund

Board of Trustees

A Board of Trustees is responsible for the operation of this Fund. The Board of Trustees consists of an equal number of Employer and Union representatives. If you wish to contact the Board of Trustees, you may use the address and phone number below:

Board of Trustees
Sheet Metal #10 Benefit Fund
1681 East Cope Avenue, Suite B
Maplewood, Minnesota 55109-2631
651-770-0991

The Board of Trustees is both the Plan Sponsor and the Plan Administrator.

As of May 1, 2018, the Trustees of this Fund are:

UNION TRUSTEES

Matt Fairbanks (Chairman of Board)
Sheet Metal Workers' Local 10
1681 East Cope Avenue
Maplewood, MN 55109

Jim Bowman
Sheet Metal Workers' Local 10
1681 East Cope Avenue
Maplewood, MN 55109

Steve Raatikka, Business Agent
Sheet Metal Workers' Local 10
1681 East Cope Avenue
Maplewood, MN 55109

EMPLOYER TRUSTEES

James Bigham
SMARCA, Inc.
1405 Lilac Drive N., Suite 100
Minneapolis, MN 55422-4598

John Quarnstrom (Financial Secretary)
SMARCA, Inc.
1405 Lilac Drive N., Suite 100
Minneapolis, MN 55422-4598

Michael Jenson
General Sheet Metal
2330 Louisiana Avenue N.
Minneapolis, MN 55427

IMPORTANT INFORMATION ABOUT THE BENEFIT FUND

Peter Leitschuh
Sheet Metal Workers' Local 10
1681 East Cope Avenue
Maplewood, MN 55109

Andy Graham
Modern Heating & Air
2318 First Street N.E.
Minneapolis, MN 55418

Michael Corcoran
Sheet Metal Workers' Local 10
1681 East Cope Avenue
Maplewood, MN 55109

Identification Number

The number assigned to this Fund by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501.

The employer identification number assigned to the Board of Trustees by the Internal Revenue Service is 41-0871191.

Plan Year

The Plan's fiscal year for the purpose of maintaining records and filing various governmental records and filing various governmental reports is the annual period January 1 through December 31.

Agent for Service of Legal Process

Ms. Sheila Rice is the Plan's agent for service of legal process. If legal disputes involving the Plan arise, any legal documents should be served upon Ms. Rice or upon any of the individual Trustees at the address shown in this Summary Plan Description.

Source of Contributions

The benefits provided by the Fund for benefits to Retirees are financed by employer contributions, a monthly premium paid by the Retirees and certain subsidies for coverage as determined by the Board of Trustees.

Plan Type

This Fund is maintained to provide hospital, surgical, medical, and dental benefits for eligible retirees and their eligible Dependents. All benefits are provided on a self-funded basis directly from the Fund's assets. All benefits are provided directly by the Plan from Plan assets.

Trust Fund

All assets are held in trust by the Board of Trustees for the purpose of providing benefits to eligible retirees and their eligible Dependents and defraying reasonable administrative expenses.

The benefits are paid according to Plan provisions out of the Trust Fund. If you have any questions or problems, you have the right to get answers from the Trustees who administer the Plan.

IMPORTANT INFORMATION ABOUT THE BENEFIT FUND

Benefits Mistakenly Paid

As a Plan Participant, you agree to comply with the Plan's rules, including but not limited to eligibility, stated in this Summary Plan Description and Plan Document. If the Plan pays benefits on your behalf, or on behalf of your Dependents, and the Plan later learns that you or your Dependents were ineligible to receive the benefits, then you or your Dependents agree to reimburse the Plan the amount of mistakenly paid benefits. If the Plan discovers that it mistakenly paid benefits on your behalf or on behalf of your Dependents, then the Plan will notify you or your Dependents in writing of the mistaken payment and of the obligation to reimburse the Plan. If you or your Dependents refuse to reimburse the Plan for mistakenly paid benefits, then the Plan may bring a lawsuit against you or your Dependents for reimbursement of the mistakenly paid benefits or may withhold from future benefits any amounts due to the Plan. Additionally, if you or your Dependents refuse to reimburse the Plan for mistakenly paid benefits, whether or not the Plan commences a lawsuit against you or your Dependents, then you or your Dependents agree to pay the Plan's costs incurred in recovering or attempting to recover the mistakenly paid benefits, including but not limited to, the Plan's reasonable attorney fees.

STATEMENT OF ERISA RIGHTS

As a Participant in the Sheet Metal #10 Benefit Fund, Retiree 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 are entitled to the rights described in this section.

Receive Information About Your Plan and Benefits

You have the right to:

1. Examine, without charge, at the Plan Administrator's office and other specified locations, such as Union halls and worksites, all Plan documents, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
2. Obtain copies of all Plan Documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You also have the right to:

1. Continue health care coverage for your spouse or your Dependents if there is a loss of coverage under the Plan because of a qualifying event. Your spouse 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.
2. Receive 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, or when your COBRA Continuation Coverage ends, if you request it before losing coverage or if you request it up to 24 months after losing coverage.

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 welfare benefit or exercising your rights under ERISA.

STATEMENT OF ERISA RIGHTS

Enforce Your Rights

If your claim for a welfare benefit is denied, 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 materials 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 Plan Administrator. If a claim for benefits is denied, in whole or in part, you may file suit in a state or federal court. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and appeals procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

If you believe that Plan fiduciaries have misused the Plan's money, or if you believe that you have been 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 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, you should contact the Employee Benefits Security Administration (EBSA) at:

National Office
Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210
866-444-3272

Nearest Regional Office:
Kansas City Regional Office
1100 Main Street, Suite 1200
Kansas City, MO 64105-5148
816-426-5131

For more information on your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by visiting the website of the EBSA at www.ebsa.gov.

STATEMENT OF NONDISCRIMINATION

The Sheet Metal #10 Benefit Fund (“Fund”) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Fund provides free aids and services to people with disabilities to effectively communicate with the Fund, such as:

- Qualified sign interpreters
- Written information in other formats (large print, audio, and accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need any of the above noted services, contact the Plan Administrator at 952-854-0795.

If you believe that the Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can contact the Plan Administrator at 952-854-0795 or you may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

APPENDIX A - RETIREE HRA PLAN

Establishment of HRA feature to Plan

The Trustees, as Plan sponsor, established the Retiree HRA Plan (“Retiree HRA”) as a feature of the Sheet Metal Local #10 Benefit Fund for Retired Participants, effective January 1, 2015 (the “Effective Date”).

Legal Status

This Retiree HRA Plan feature is intended to qualify as a medical reimbursement arrangement under Code sections 105 and 106 and the related regulations, and as a Health Reimbursement Arrangement as defined under IRS Notice 2002-45, and shall be interpreted to accomplish that objective. The Retiree HRA Benefits reimbursed under this Retiree HRA are intended to qualify as Medical Care Expenses eligible for exclusion from a Retiree’s income under Code section 105(b).

Definitions Applicable to Retiree HRA Plan

“Retiree HRA Benefits” means the reimbursement of benefits for Retiree premiums described in the *Eligible Retiree HRA Benefits* section below.

“Retiree HRA Account” means the HRA Account described under the “Establishment of Retiree HRA Account” section.

“Retiree” means a retiree eligible for benefits under the Sheet Metal #10 Benefit Fund for Retired Participants.

Eligibility to Participate

A Retiree is eligible to participate in the Retiree HRA as long as they meet the “Eligibility Rules” as detailed on page 17 of this Plan Document.

Conversion of Dollar Bank to Retiree HRA Account

At retirement, a Retiree’s Dollar Bank in the Sheet Metal #10 Benefit Fund will be converted to a Retiree HRA Account for use under the Sheet Metal #10 Benefit Fund for Retirees and their Dependents as further detailed below. In no event will Retiree HRA Benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Retiree HRA Benefits.

Establishment of Retiree HRA Account

A Retiree HRA Account will be established and maintained with respect to each Retiree, but will not create a separate fund or otherwise segregate assets for any individual Participant for this purpose. The HRA Account so established will merely be a recordkeeping account for the purpose of keeping track of contributions and available reimbursement amounts from the Trust.

APPENDIX A – RETIREE HRA PLAN

- *Crediting of Accounts.* The Retiree HRA Account will be credited with the dollar-for-dollar amount of the Retiree’s Dollar Bank balance at the time of the Retiree’s election for Retiree coverage.
- *Debiting of Accounts.* An Individual’s Retiree HRA Account will be debited in the amount of the monthly premium required for Retiree coverage under this Plan only until such time as (1) the Retiree Opts-Out of coverage under the Sheet Metal #10 Benefit Fund for Retired Participants, (2) exhausts their Retiree HRA Account, or (3) otherwise loses coverage due to another provision of the Retiree Plan.
- *Available Amount.* The amount available for debiting of Retiree premiums from the Retiree HRA Account to the Sheet Metal #10 Benefit Fund for Retired Participants is the amount credited to an HRA Account reduced by prior monthly debits from the Retiree HRA Account to pay for coverage.

Eligible Retiree HRA Benefits

The Plan will deduct the cost of the required monthly premium for Retiree coverage for this Plan from the Retiree’s Retiree HRA Account balance. No other form of medical expense benefits or premiums will be eligible for reimbursement from the Retiree’s Retiree HRA Account.

Termination of Participation

Retirees will have their Eligibility terminate pursuant to the “Termination of Eligibility” provisions on page 20 of this Plan Document.

Maximum Annual Benefit

There is no annual maximum benefit under the Retiree HRA Account. The Retiree may use their Retiree HRA Account as long as they remain eligible under the Plan and there is a Retiree HRA Account balance.

If You Return to Active Employment

In the event a Retiree returns to active employment and qualifies for active coverage under the “Re-Qualifying Eligibility” provisions of the Sheet Metal #10 Benefit Fund for Active Participants, the Retiree’s Retiree HRA Account will be frozen. The Retiree HRA Account will not be converted back to a Dollar Bank. If the Retiree once again retires and gains eligibility for coverage under this Plan, their Retiree HRA Account will be unfrozen and once again available for use to pay for coverage under this Plan.

APPENDIX A – RETIREE HRA PLAN

Spend Down/Forfeitures

In the event the Retiree dies the balance in his HRA Account will be available for use by his Dependents, if any, to continue to pay for coverage under this Plan until such time as the Retiree HRA Account is exhausted.

Funding This Plan Feature

All of the amounts payable under this Retiree HRA Account Plan will be paid from the general assets of the Trust. Nothing in this description will be construed to require the Trustees to maintain any fund or to segregate any amount for the benefit of any Retiree, and no Retiree or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Trust from which any payment under this Retiree HRA Account Plan may be made.