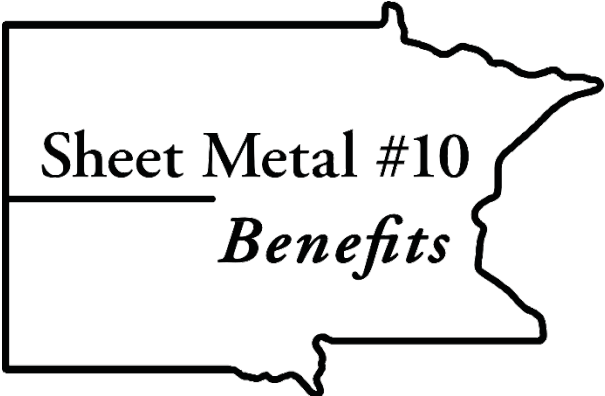


**SHEET METAL #10 BENEFIT FUND
RESTATED SUMMARY PLAN DESCRIPTION
AND PLAN DOCUMENT**

NOVEMBER 2024



November 2024

To All Active Eligible Employees:

We are pleased to provide you with this revised Summary Plan Description (SPD). We are proud of the comprehensive benefits package that is provided to you and your family.

This SPD describes the eligibility requirements for coverage and the benefits provided through the Sheet Metal #10 Benefit Fund as of November 1, 2024. The most significant change to the SPD occurred on January 1, 2024 when the Plan changed from Blue Cross Blue Shield of Minnesota to UMR using the UnitedHealthcare Choice Plus Network as its medical network provider. Beyond the change from Blue Cross to UMR, there have been many other changes to the Plan so please read your SPD carefully and share it with your family. For example, some other important changes are highlighted below:

- Telehealth: The Plan increased the telehealth benefit to provide 80/20 coverage at any in-network telehealth provider.
Please note there remains NO coverage for out-of-network telehealth services.
- Teladoc: The Plan's preferred provider for telehealth services is now through Teladoc and no longer through Doctor on Demand. Teladoc provides telehealth medical, mental health, and dermatology assistance. Teladoc Services are covered at 100%.

You can expect future changes to the Plan prior to another re-write of this document. These changes will be communicated via Summary of Material Modification (SMM) notifications which will be mailed to you. Please read SMMs carefully and keep them with this document for full Plan rules.

This SPD is designed to help you understand the benefits available to you and reference the following specific sections:

- Schedule of Benefits, which begins on Page 2, summarizes the benefits including medical, dental, vision, prescription drug and disability that are available to you and your family under the Plan;
- Important Contact Information, page 9, provides contact information for the various benefits provided by the Plan;
- Glossary of important definitions, pages 12-21;
- Eligibility, pages 22-38, which explains eligibility for coverage for you, your spouse and dependents;
- How your Major Medical Benefits are paid, pages 50-53;
- Covered Major medical benefits, pages 53-60;
- General exclusions and limitations of coverage, pages 74-77; and
- Information about how to file claims and appeals, pages 78-89.

In addition to these sections, throughout this SPD there are boxes highlighting important points and tips on how to get the most out of your benefits.

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.

Further, it is important you understand the Sheet Metal #10 Benefit Fund is a self-insured Plan. That means the Plan is funded by employer contributions based on the hours you work under a collectively bargained agreement through Local #10. The Plan is not a fully insured Plan provided by the vast resources of an insurance company. Rather, this is *your* health fund and therefore while we encourage you to use your benefits, we also urge you to use them wisely.

For example, using in-network providers whenever possible is extremely important. In-network providers have contracted to provide services at discounted rates that save both you and the Plan money. Use emergency rooms services when appropriate, but if you are not experiencing a medical emergency, consider the cost savings for both you and the Plan by using retail/walk in clinics or Teladoc. Being a good steward of the Plan and its assets saves you money in out-of-pocket expenses in the short run, but as an “owner” of the Plan, it also saves you and the Plan in the long run.

If you have any questions regarding your many benefits under the Plan, contact Wilson-McShane Corporation as claims manager, or the Benefit Office. The success of the Plan is due to the cooperation received from the Union, contributing employers, and eligible employees. We and the Benefit Office staff are grateful for your continued cooperation.

Sincerely yours,

Board of Trustees - Sheet Metal #10 Benefit Fund

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 have the discretion to interpret and construe the rules of the Plan and the terms of this booklet. Participants will be notified of any Plan changes in writing.

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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

Most employees will be covered under Plan A coverage. Plan B coverage, as described below, is a reduced benefit medical Plan which is available to certain classifications of employees in specific areas of Sheet Metal Workers Local #10. Refer to the applicable wage/fringe package in your area to determine your Plan B options, if any.

Please note that there is more detail regarding how your medical benefits are paid both in- and out-of-network (including specific examples) on pages 50-53. Further detail about specific covered Major Medical Expense Benefits begins on page 53.

Eligible Employees Only		
Benefit	Coverage – Plan A	Coverage – Plan B
Death Benefit (see page 45)	\$10,000	\$10,000
Accidental Death and Dismemberment Benefit (see page 46)		
Loss of life	\$10,000	\$10,000
Loss of two limbs, sight in both eyes, or one limb and sight in one eye	\$10,000	\$10,000
Loss of one limb or sight in one eye	\$5,000	\$5,000
Weekly Sickness and Accident Benefit (Non-Occupational Only) (see page 47)		
<i>Journeyman in any contract area</i>		
Weekly Maximum	\$550	\$550
Hourly Rate for Partial Daily Benefit	\$13.75	\$13.75
Maximum	\$14,300 per disability	\$14,300 per disability
<i>All Other Classifications</i>		
Weekly Maximum	\$400	\$400
Hourly Rate for Partial Daily Benefit	\$10.00	\$10.00
Maximum	\$10,400 per disability	\$10,400 per disability
<i>Note: Weekly Sickness and Accident Benefits are considered taxable income.</i>		

Eligible Employees and Dependents		
Major Medical Expense Benefit	Coverage – Plan A	Coverage – Plan B
<i>(See pages 53-60 for a listing of services covered as Major Medical Expenses)</i>		
Annual Deductible		
Before the Plan pays for most covered expenses, you pay	\$145 per person each year; \$435 family maximum	\$645 per person each year; \$1,935 family maximum
Coinsurance		
Once you meet your annual deductible, the Plan pays	80%, up to the annual out-of-pocket maximum	80%, up to the annual out-of-pocket maximum

SCHEDULE OF BENEFITS

Eligible Employees and Dependents Major Medical Expense Benefit	Coverage – Plan A	Coverage – Plan B
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.	\$1,160 per person; \$3,480 family maximum	\$1,935 per person; \$5,805 family maximum
Teladoc (see page 73) Preferred provider for on demand virtual Medical, Dermatology and Behavioral Health visits	100%	100%
Telehealth Office Visits Scheduled virtual office visits with your primary or specialist care provider. (Except for Teladoc visits which are covered at 100%)	100% after annual deductible Out-of-Network Telehealth Office Visits are not covered.	100% after annual deductible Out-of-Network Telehealth Office Visits are not covered.
(Immunizations (see next row for immunizations administered at a pharmacy)	100% of Reasonable and Customary after deductible (100% if under age 19)	100% of Reasonable and Customary after deductible (100% if under age 19)
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	100% of Reasonable and Customary, no deductible
Emergency Room Services	80% after annual deductible also subject to \$50 copayment, waived if you are admitted to hospital	80% after annual deductible also subject to \$50 copayment, waived if you are admitted to hospital
Inpatient In-Network Hospital Coverage	80% after annual deductible	80% after annual deductible
Inpatient Out-of-Network Hospital Coverage	No coverage	No coverage
Mental/Behavioral and Substance Abuse Disorder – In-Network Inpatient Service	80% after annual deductible	80% after annual deductible
Mental/Behavioral and Substance Abuse Disorder – Out-of-Network Inpatient Service	No coverage	No coverage

SCHEDULE OF BENEFITS

Eligible Employees and Dependents Major Medical Expense Benefit	Coverage – Plan A	Coverage – Plan B
Mental/Behavioral and Substance Abuse Disorder – In-Network Outpatient Service	80% after annual deductible	80% after annual deductible
Mental/Behavioral and Substance Abuse Disorder – Out-of-Network Outpatient Service	80% after annual deductible	80% after annual deductible
Bariatric Surgery (see page 58)	80% after deductible subject to \$25,000 lifetime maximum	80% after deductible subject to \$25,000 lifetime maximum
Chiropractic Treatment Office visits	80% after annual deductible up to a maximum of \$30 per visit	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 Rayus facility, then charges will be paid at 100% after the annual deductible.	80% after annual deductible*	80% after annual deductible*
Elective Sterilization	80% of Reasonable and Customary, deductible applies	80% of Reasonable and Customary, deductible applies
Hearing Care Plan Coinsurance – One examination per Calendar Year 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 after annual deductible \$1,000 per hearing aid	80% of Reasonable and Customary after annual deductible \$1,000 per hearing aid
Health Education Plan Coinsurance	80% after the deductible	80% after the deductible
Home Health Care Maximum days per Calendar Year	80% after annual deductible 120 days	80% after annual deductible 120 days

SCHEDULE OF BENEFITS

Eligible Employees and Dependents Major Medical Expense Benefit	Coverage – Plan A	Coverage – Plan B
Hospice Care Lifetime Maximum	80% after annual deductible 185 days	80% after annual deductible 185 days
Lodging Benefit (see page 60)	\$30/night; 90-day maximum	\$30/night; 90-day maximum
Orthotics Plan Coinsurance	80% up to the first \$300 after deductible and then 50% of all remaining costs	80% up to the first \$300 after deductible and then 50% of all remaining costs
Physical Therapy	80% after annual deductible	80% after annual deductible
Routine Physical Examination (one per year – including cancer exam)	80% after annual deductible	80% after annual deductible
Skilled Nursing Care Daily room and board Confinement maximum	100% reasonable and customary after annual deductible 90 days; must have at least 60 days in between related confinements	100% reasonable and customary after annual deductible 90 days; must have at least 60 days in between related confinements
Smoking Cessation (see page 71) Nicotine replacement therapy aids Oral Prescription Medications	100% reimbursement after annual deductible 80% name brand; 90% generic	100% reimbursement after annual deductible 80% name Brand; 90% generic
Speech & Occupational Therapy Lifetime visit limit	80% after annual deductible up to a lifetime maximum of 35 visits	80% after annual deductible up to a lifetime maximum of 35 visits
Speech Therapy Benefit (additional to that listed above) 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	80% after annual deductible

SCHEDULE OF BENEFITS

Eligible Employees and Dependents		
Major Medical Expense Benefit	Coverage – Plan A	Coverage – Plan B
Temporomandibular Joint Disorder (TMJ)	80% of Reasonable and Customary after deductible up to the first \$600 and then 50% of all remaining TMJ benefits	80% of Reasonable and Customary after deductible up to the first \$600 and then 50% of all remaining TMJ benefits
Wigs for Hair Loss Due to Chemotherapy or Illness	One wig (per life) up to \$500 after deductible	One wig (per life) up to \$500 after deductible
Prescription Drug Benefit (see page 61)		
Prescription Drugs	Coverage – Plan A	Coverage – Plan B
	Not subject to deductible and out-of-pocket limits. Plan pays 90% for generic prescription drugs, and 80% for brand name prescription drugs	Not subject to deductible and out-of-pocket limits Plan pays 90% for generic prescription drugs, and 80% for brand name prescription drugs
Out-of-Network Retail Pharmacy	Plan reimburses 80% after annual deductible	Plan reimburses 80% after annual deductible
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% after annual deductible	Plan pays 90% after annual deductible
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. If you use the Specialty Drug Program If you do not use the Specialty Drug Program	Plan pays 100% Not covered	Plan pays 100% Not covered

SCHEDULE OF BENEFITS

Dental Care Benefit (see page 65)	Coverage – Plan A	Coverage – Plan B
Calendar Year deductible (Coverage B, C and D Services) Individual Family	\$50 \$150	\$50 \$150
Note: Deductible does not apply for individuals under age 19. Maximum every two Calendar Years This maximum will not apply to an individual under age 19 for Dental Care Benefits under Coverage A, B and C.	\$3,000	\$3,000
Lifetime Maximum for Coverage D services (unless medically necessary). This maximum will not apply to an individual under age 19 for non-cosmetic orthodontic services.	\$3,000	\$3,000
Plan Coinsurance Coverage A service Coverage A choice PPO provider service provided by Delta Dental Coverage B services Coverage C services Coverage D services See pages 65-67 for a description of each coverage category.	80% of Reasonable and Customary 85% of Reasonable and Customary 80% of Reasonable and Customary 50% of Reasonable and Customary 80% of Reasonable and Customary	80% of Reasonable and Customary 85% of Reasonable and Customary 80% of Reasonable and Customary 50% of Reasonable and Customary 80% of Reasonable and Customary

SCHEDULE OF BENEFITS

Vision Care Benefit (See page 69)	Coverage – Plan A	Coverage - Plan B
Two year maximum for each member and eligible dependent individuals 19 and older (the two-year periods are 2024-2025 and then 2026-2027 etc):	\$350 (in 2024-2025 and another \$350 in 2026-2027 etc)	\$350 (in 2024-2025 and another \$350 in 2026-2027 etc)
For individuals under age 19:	100% coverage	100% coverage
One routine eye exam per year.	100% coverage on the first \$350. 50% on any additional eyewear expense above \$350, subject to one additional pair of glasses or one set of contacts, which may be one of the following:	100% coverage on the first \$350. 50% on any additional eyewear expense above \$350, subject to one additional pair of glasses or one set of contacts, which may be one of the following:
Eyewear	<ul style="list-style-type: none"> • A single purchase of “non-disposable” or • A 12-month supply of “daily disposable” or • A 6-month supply of “non-daily disposable” 	<ul style="list-style-type: none"> • A single purchase of “non-disposable” or • A 12-month supply of “daily disposable” or • A 6-month supply of “non-daily disposable”
LASIK eye surgery	\$500	\$500

IMPORTANT CONTACT & BENEFIT PROGRAM 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
Death and Accidental Death and Dismemberment Claims	Benefit Office Sheet Metal #10 Benefit Fund 1681 East Cope Avenue, Suite B Maplewood, MN 55109-2631	800-396-2903 651-770-0991 Fax: 651-770-1351	www.smw10.org
To find a preferred provider:			
Medical	UnitedHealthcare (UHC) Choice Plus Network	800-535-6373 or (952) 854-0795	www.umar.com
Dental	Delta Dental	800-570-1012 or 218-728-4231	www.deltadentalmn.com
Vision	VSP	800-877-7195	www.vsp.com
View claims information, find providers and order ID cards	UnitedHealthcare (UHC)	Use website	www.umar.com
Employee Assistance Plan	TEAM	651-642-0182 800-634-7710	www.startwithteam.com
Prescription Drugs	Prime Therapeutics	800-509-0545	www.myprime.com
Diagnostic Imaging	Rayus Radiology	866-765-7138	www.rayusradiology.com
Hearing Benefits	EPIC Hearing Healthcare	866-956-5400	www.epichearing.com
Smoking Cessation Benefits	UnitedHealthcare (UHC)	800-207-7680	www.umar.com
Teladoc	Online medical and mental health service through United Healthcare	800-TELADOC (835-2362)	www.teladochealth.com
Maternity Management Support	UnitedHealthcare (UHC)	888-438-8105	www.umar.com
Address changes, beneficiary forms	Benefit 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 Benefit Office whenever you:
 - Change your home, mailing address, e-mail or phone number;
 - Change your beneficiary;
 - Become disabled or return to work after such disability ends;
 - Enter and return from the uniformed services of the United States;
 - Gain a new Dependent (note: the following proof must be submitted to enroll a new eligible Dependent):
 - Spouse - marriage certificate;
 - Child – birth certificate showing member as parent;
 - Stepchild - marriage certificate, divorce decree and/or paternity orders;
 - Children born outside of the marriage - birth certificate, paternity order, dependent affidavit and, if necessary, documentation that support for the Dependent is required;
 - Adoption - adoption papers/placement papers;
 - Change marital status (please note that your ex-spouse is no longer eligible on the date of your 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.
- The current Preferred Provider Organizations (PPOs) or care providers the Plan uses are listed on the prior page under Important Contact Information. The Plan reserves the right to change or discontinue any PPO at any time.

- Retiree Coverage Note: Retiree coverage requires that you have at least 11,500 hours of contributions immediately preceding retirement. If you terminate your coverage under the Plan for any reason, the hours you accumulated prior to your termination will be lost and if and when you restart employment, your hours total for purposes of retiree coverage eligibility will start at zero.
- The Plan may receive rebates from Prime Therapeutics for prescriptions purchased under the Plan. These rebates will be used to reduce total Plan expenses.

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.

Active Eligible Employees' Plan: The benefits of this Plan for active eligible employees and their Dependents.

Actively at Work: The eligible employee is employed in, available for, or would be available for (except for being disabled) bargained or non-bargained work where contributions are required to be made to this Fund. An eligible employee who has retired from the trade and who is applying his or her Dollar Bank to maintain active coverage for up to three months is also considered Actively at Work.

Age 65: The age attained at 12:01 a.m. on the first day of the month in which the eligible person's 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.

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

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 of the patient, a review of laboratory and x-ray examinations, an examination of the patient, 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 the patient 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.

Contributing Employer: Any employer who, pursuant to the terms of a collective bargaining agreement or a participation agreement, agrees to contribute to the Sheet Metal #10 Benefit Fund for hours worked by individuals employed by such employer. Local #10, the Sheet Metal Local #10 Control Board Trust Fund, and any Joint Apprentice and Training Committee (JATC) affiliated with Sheet Metal

DEFINITIONS

#10 and Sheet Metal, Air Conditioning & Roofing Contractors Association, Inc. (SMARCA) are also considered Contributing Employers.

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:

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), which is:
 - 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;
 - 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 Benefit 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

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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
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.

DEFINITIONS

Fund Administrator: The Fund's Board of Trustees.

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 the continued care and treatment of an eligible person who is under the care of a Physician and who would need Hospital confinement without home health care. A Home Health Care Plan must be:

1. Approved in writing by the attending Physician and the home health care provider;
2. Certified by a Physician that hospitalization would be required if home health care is not used; and
3. 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.

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:

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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 Health 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 Substance Use Disorders, 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.

The Plan has retained United Healthcare (UHC) as the medical network provider for the Plan's Major Medical Expense Benefits. Unless otherwise stated in the Plan, in determining whether a treatment or service is Medically Necessary, the Board of Trustees will rely upon UHC to make such determinations consistent with UHC's medical policies and such medical policies are incorporated into the Plan by reference.

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.

DEFINITIONS

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.

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).

Mental Health Professional: A person providing clinical services in the treatment of Mental Health Disorders and/or Substance Use Disorders who holds all of the prerequisite licenses and/or certifications required by law to provide clinical services and/or meets the certification requirements of the applicable state or national professional governing body necessary to work in at least one of the following disciplines:

1. Psychiatric Nursing;
2. Clinical Social Work;
3. Psychology;
4. Psychiatry;
5. Licensed Professional Clinical Counseling; and
6. Certified Drug and Alcohol Counseling.

Non-Occupational Injury Disease or Illness: An injury, disease or illness 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.

DEFINITIONS

Owner-Member: An owner, agent, contractor, subcontractor, jobber, or any other person who is directly or indirectly financially interested in or who is an officer or otherwise involved in the management of a sheet metal shop, business, or job. An Owner-Member includes; but is not limited to, a person who meets all three of the following requirements:

1. The person is an employee of:
 - a. An incorporated business if the employee is an officer, director or an owner of the business: or
 - b. Any business enterprise, however organized, in which the business is owned or controlled by the employee and a member of the employee's family (which includes the employee's spouse and lineal ascendants and descendants and the spouse's lineal ascendants and descendants);
2. The person is a member of the union in good standing; and
3. The person performs work covered by the terms of a collective bargaining agreement to which Local #10 is a party.

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

Participation Agreement: A written agreement, other than a collective bargaining agreement, which allows the eligible employees of a Contributing Employer to participate in the Plan.

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 (LICSW), nurse practitioners, physician's assistants, 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 to 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.

DEFINITIONS

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.

Prior Authorization: Is the process of determining benefit coverage prior to a service being rendered to an individual Participant. A determination is made based on Medical Necessity criteria for drugs, supplies, tests, procedures, and other services that are appropriate and cost-effective for the Participant. This Participant-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent, and duration of stay.

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 employee's child as an alternate recipient. Such order must be approved by the Board of Trustees and the child must meet the definition of a Dependent.

Reasonable and Customary: The Reasonable and Customary rate is the negotiated rate the Plan pays to the provider for an In-Network medical claim, minus any copayment, deductible, or coinsurance that the Participant is responsible for paying. If a network contract is in place, the network contract determines the Plan's Reasonable and Customary Charge. The Plan's Network is the United Healthcare Choice Plus Network.

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.

DEFINITIONS

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;
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 Prime Therapeutics 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.

DEFINITIONS

Substance Use Disorder: A mental or behavioral disorder 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 months or less.

Totally Disabled or Total Disability: The complete inability to engage in your own occupation for wage or profit.

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

UnitedHealthcare (UHC/UMR): The Plan's medical network provider is UMR, a UnitedHealthcare Company (UHC). Any reference in this document to United Healthcare, UHC or UMR is a reference to the Plan's medical network provider.

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Collectively Bargained Employees

You will become eligible for benefits if:

- You perform work that is under the jurisdiction of collective bargaining agreements between the Sheet Metal Workers Local Union 10 and Contributing Employers; and
- You meet the requirements of initial or continuing eligibility.

<p>Non-Bargained Employees; There are different eligibility rules for Non-Bargained Employees. Contact the Benefit Office for a copy of non-bargained eligibility rules.</p>

Coverage Election

Certain employees have the option to elect either single or family coverage or a reduced medical benefit option called Plan B. These elections are only available for certain employees working in specific classifications under particular collective bargaining agreements. You should review the wage/fringe information in your area to determine if these coverage elections are available to you and to understand any impact an election change may have on taxable base. If you elect single coverage, your Dependents will not be covered. If you have chosen single coverage, you may only enroll Dependents by electing family coverage at open enrollment or when your Dependents lose other group coverage due to:

- Legal separation;
- Divorce;
- Death;
- Dependent termination of employment (voluntary or involuntary);
- Dependent exhaustion of COBRA Continuation Coverage;
- Dependent reduction in hours; and
- Dependent no longer meets the definition of Dependent under that coverage.

Open Enrollment

If you are in a classification that allows for single coverage, there is an annual open enrollment period that allow you to add your Dependents to coverage. The annual open enrollment period is November 1st through November 30th of each year and open enrollment election changes will be first effective on the following January 1st.

The Trustees have the right to change these rules, including eliminating the single coverage or Plan B coverage category altogether.

Important Note Regarding Plan B and Subsidized Retiree Coverage: If you elect for Plan B coverage you will not be eligible for subsidized retiree coverage which will significantly impact the cost of retirement health coverage. Please contact the Benefit Office if you have any questions.

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Medical Examination

A medical examination is not required to become covered under this Plan.

Initial Eligibility

If you were never eligible under the Plan before, you will become eligible on the first day of the calendar month following one lag month after your first eight hours of covered employment. You will remain eligible for two months. Initial eligibility for existing employees of newly organized companies are not subject to the lag month. If you are not Actively at Work, you will lose eligibility and will forfeit any individual Dollar Bank balance except when specifically indicated otherwise.

Actively at Work:

The eligible employee is employed in, available for, or would be available for (except for being disabled) bargained or non-bargained work where contributions are required to be made to this Fund.
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Dollar Bank

An individual dollar bank is used to hold employer contributions and is used each month to determine and pay for your monthly health coverage. Your Dollar Bank will be used to continue your eligibility in the Plan if you are Actively at Work and you do not meet the Continued Eligibility requirements (see page 24).

When you first qualify as an eligible employee under the Initial Eligibility rules, you will have a negative balance in your Dollar Bank. This negative balance will be calculated as the value of the difference between the actual contributions received due to hours worked in your first month and the cost of two months of coverage. This negative balance can be depleted by any amounts received on a monthly basis that exceed the required amount for coverage.

For each month in which you attain initial or continuing eligibility, all contributions will be deposited in your Dollar Bank. The cost of coverage (premium) for the applicable eligibility month will then be drawn from your dollar bank account. The required amount will be established by the Trustees based on the benefit cost of the Plan plus administrative expenses.

If you do not attain eligibility, all contribution hours from that month will be forfeited. However, if you attain or maintain eligibility any contributions made on your behalf beyond the full cost of coverage will remain in your Dollar Bank. In addition, if you are not Actively at Work you will lose eligibility, and your Dollar Bank will be forfeited.

The maximum you can accrue under your Dollar Bank is \$35,000.

Note that when funding your Dollar Bank from \$30,000 to \$35,000, 50% of the contributions made on your behalf beyond the full cost of coverage will be credited to your Dollar Bank. This will continue until your balance reaches the maximum amount of \$35,000. Please note that your Dollar Bank is not a vested benefit.

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EXAMPLE – INITIAL ELIGIBILITY

YOU BEGIN WORK ON JUNE 2. YOU WILL BECOME ELIGIBLE ON AUGUST 1 AND REMAIN ELIGIBLE FOR AUGUST AND SEPTEMBER. HERE IS HOW THE BALANCE OF YOUR DOLLAR BANK WILL LOOK:

COST FOR AUGUST ELIGIBILITY	-	\$1,676 FROM DOLLAR BANK
COST FOR SEPTEMBER ELIGIBILITY	-	\$1,676 FROM DOLLAR BANK
CONTRIBUTIONS FOR JUNE WORK (100 HOURS AT \$11.56/HR)	+	<u>\$ 1,156 INTO DOLLAR BANK</u>
BALANCE IN DOLLAR BANK	=	(\$2,196) NOTE: THIS IS A NEGATIVE BALANCE

IF CONTRIBUTIONS FOR YOUR WORK ARE MORE THAN THE PREMIUM AMOUNT IN A MONTH, THE EXCESS CONTRIBUTIONS ARE USED TO OFFSET THE NEGATIVE BALANCE IN YOUR DOLLAR BANK. FOR EXAMPLE, IF CONTRIBUTIONS FOR JULY ARE MORE THAN \$1,676, THEN THE EXCESS WOULD BE USED TO OFFSET THE NEGATIVE BALANCE IN YOUR DOLLAR BANK.

Requalifying Eligibility

If your previous coverage in this Plan ceased for any reason, and you are requalifying for benefits under the Plan, you will become eligible on the first day of the third calendar month following any month in which contributions were required to be made on your behalf to the Plan that were equal to or exceeded the premium amount. If your employer contributions are less than the premium amount in the starting month and your employer reports at least 80 hours, you will be permitted to pay the difference between the contributions made and the full cost of coverage, at the hourly rate in force at the time of the starting month. Contact the Benefit Office for the current monthly premium amount.

EXAMPLE –REQUALIFYING ELIGIBILITY

IF THE TOTAL CONTRIBUTIONS REQUIRED FOR COVERAGE ARE \$1,676 PER MONTH AND \$1,676 OF CONTRIBUTIONS ARE MADE FOR YOU IN JUNE, THEN YOU WILL BE ELIGIBLE IN SEPTEMBER.

Under either of the above eligibility provisions (initial or requalifying), your benefits will still become effective if you are not Actively at Work because of disability on the date you gain or regain eligibility. Weekly Sickness and Accident benefits will only be paid for dates of disability that follow your eligibility date. For example, if you become eligible September 1st from contributions for work in June, but are disabled on September 1st due to an injury that occurred in August, you will receive Weekly Sickness and Accident Benefits for the time you continue to be disabled after September 1st, subject to the Plan's limitations on Weekly Sickness and Accident Benefits. You must maintain coverage in order to receive the Weekly Sickness and Accident Benefits. Maintaining your coverage would require you paying premiums for coverage after September 1st.

Continued Eligibility

Once you meet the Initial Eligibility requirements, you will continue to be eligible for benefits if you are Actively at Work and one of the following conditions is satisfied. The Benefit Office will check these

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conditions in the order in which they are listed to determine if you are eligible to have your coverage continued.

- You must have sufficient contributions made for your work month. As the chart below indicates, your work month dictates coverage for the third month following the work month.

Contributions for this work month	Pay for coverage this month
January	April
February	May
March	June
April	July
May	August
June	September
July	October
August	November
September	December
October	January
November	February
December	March

EXAMPLE – CONTINUED ELIGIBILITY WITH SUFFICIENT CONTRIBUTIONS

IF THE TOTAL CONTRIBUTIONS REQUIRED FOR COVERAGE ARE \$1,676 PER MONTH AND AT LEAST \$1,676 OF CONTRIBUTIONS ARE MADE FOR YOU IN JUNE, THEN YOU WILL BE ELIGIBLE IN SEPTEMBER.

Your coverage will also continue if,

- Employer contributions for the third month prior plus your available Dollar Bank balance equal the monthly premium requirement.

EXAMPLE – CONTINUED ELIGIBILITY THROUGH BANK DOLLARS

THE TOTAL CONTRIBUTION REQUIRED FOR COVERAGE IS \$1,676. EMPLOYER CONTRIBUTIONS FOR YOU ARE \$966 IN JUNE. \$710 WILL BE SUBTRACTED FROM YOUR DOLLAR BANK TO PROVIDE COVERAGE IN SEPTEMBER.

When your Dollar Bank is depleted, you may continue coverage for Plan medical benefits by making self-payments for the Plan's Special Continuation Coverage or COBRA Continuation Coverage, subject to the eligibility requirements of each.

- Employer contributions for the third month prior plus self-pay contributions equal the self-payment rate determined by the Trustees (this is known as Special Continuation Coverage; see page 31); or

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EXAMPLE – CONTINUED ELIGIBILITY THROUGH SELF-PAYMENT

THE SELF-PAYMENT REQUIRED FOR COVERAGE IS \$1,676 AS DETERMINED BY THE TRUSTEES. EMPLOYER CONTRIBUTIONS FOR YOU ARE \$966 IN JUNE AND YOU HAVE NO OTHER PREVIOUS DOLLAR BANK BALANCE, YOU WILL HAVE TO PAY \$710 TO HAVE COVERAGE IN SEPTEMBER.

- You are eligible for COBRA Continuation Coverage, and you remit the required COBRA Contribution payment when due. (See page 33.)

Owner members cannot “self-pay” for coverage. However, Dollar Bank and Sheet Metal #10 SAFE balances could be applied to maintain coverage.

Dollar Bank Usage – Transition of Non-Bargaining Unit Employee: If you switch from being a bargaining unit employee to a non-bargaining unit employee and continue to work for a signatory employer, you will be allowed to either (1) continue to use your Dollar Bank to pay for Plan coverage; or (2) freeze your Dollar Bank. To freeze your Dollar Bank, you must provide written notice to the Benefit Office of your desire to freeze your Dollar Bank. Please note that a frozen Dollar Bank does not create eligibility for retiree coverage. In addition, a frozen Dollar Bank cannot be used to pay for non-bargained retiree health coverage. A freeze will benefit you only if you return to active bargained work. You will not be able to elect bargained retiree coverage using a frozen dollar bank directly from non-bargained status.

Retiree Coverage Note: Retiree coverage requires that you have maintained active coverage for at least 11,500 hours of contributions immediately preceding retirement. If you terminate your coverage under the Plan for any reason, the hours you accumulated prior to your termination will be lost, and if and when you restart employment, your hours total for purposes of retiree coverage eligibility will start at zero.

When you retire, coverage for you and your Dependents will end under the Active Eligible Employees’ Plan at the end of the month with your last day worked unless you use Dollar Bank reserves to continue active coverage for a maximum of three months. You may be eligible for retiree coverage if you meet the eligibility requirements or you can elect COBRA Continuation Coverage. If you are eligible for retiree coverage, your Dollar Bank will convert to a Retiree HRA as further described below and in the Retiree Summary Plan Description.

Dollar Bank Conversion to Retiree HRA Account: Your Dollar Bank will be converted to a Retiree HRA Account to be administered under the Retiree HRA Account Plan section of the Sheet Metal #10 Benefit Fund for Retired Participants (retiree Plan). Under the retiree Plan you can use your Retiree HRA Account to pay for coverage under the Sheet Metal #10 Benefit Fund’s Retiree Plan.

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If you retire and are unable to meet the 11,500-hour contribution requirement for retiree Plan coverage, you may still be able to convert your remaining unused Dollar Bank to an HRA Account for use under the retiree Plan if:

- You have not suffered a break in coverage, or elected for the active opt-out option, since first becoming eligible under this Plan; and,
- You have met a twenty-five (25) year vesting requirement with the Sheet Metal Workers' Local 10 Pension Fund.

If you are eligible under this above noted exception, you will be eligible to use your converted HRA Account under the retiree Plan, even though you are not eligible for any other benefits under that Plan.

Reciprocal Agreement

You may be able to maintain your eligibility if you work in the jurisdiction of a reciprocal fund under the terms of the reciprocal agreements entered into by the Fund. Contributions received by the Fund will be credited by dividing the total dollar amount received by the current contribution rate. Eligibility and Dollar Bank will be treated the same. You must request reciprocity in writing to ensure contributions are reciprocated correctly and efficiently. For more information about reciprocal agreements, contact the Benefit Office.

Non-Bargaining Unit Employees

If you are a full-time non-bargaining employee for a Contributing Employer who has agreed to contribute to the Fund under the terms of the special agreement providing for the coverage of all non-bargaining unit employees, you become eligible no later than the first day of the month after the Fund receives your employer's payment for your coverage. Your Continued Eligibility to participate is dependent on your status as a non-bargaining unit employee and the employer's payment of the required premiums outlined in the special agreement. Contact the Benefit Office for more information

Dependents

If you meet the eligibility requirements explained above and have elected applicable coverage, your Dependents will be eligible for benefits under this Plan if they:

- Meet the definition of Dependent (see definition on page 13); and
- Are not members of the uniformed services of the United States.

New Dependents will become eligible for benefits when they meet the definition of Dependent. Dependents of eligible employees who have elected single coverage are not covered. Single coverage is available in limited contract areas only.

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If you and your spouse are both eligible employees under this Plan or have coverage with another Plan, benefit payments for Dependents will be subject to Coordination of Benefits and no more than 100% of covered expenses will be paid.

Spouse or Dependent Child HSA Opt-Out

Your spouse or dependent child may elect to opt-out of coverage under this Plan only if they are eligible for a Health Savings Account (HSA) paired with a high-deductible health Plan (HDHP) provided by their employer. By having your spouse or dependent opt-out of coverage under the Plan, you, your spouse or your dependent understand that:

- Your spouse or dependent will not be entitled to any benefits or other payments from the Plan, including, but not limited to, health care benefits, prescription drug benefits, dental benefits, vision care or any other form of benefits under the Plan.
- You will have no right or claim to any contributions made to the Plan for the purposes of funding your spouse or dependent's eligibility for coverage.
- Your spouse or dependent forfeits any right to benefits under the Plan even if Plan benefits are superior in some respects to the benefits under the Plan offered by their employer.
- Your spouse and/or dependent may return to coverage under the Plan under the following circumstances.
 - The spouse or dependent drops their coverage under their employer's Plan during the employer's annual open enrollment period.
 - The spouse or dependent loses coverage under their employer's Plan due to a termination of employment.
 - The spouse or dependent otherwise suffers a special enrollment event as required by the Health Insurance Portability and Account Ability Act (HIPAA).
 - The spouse or dependent otherwise meets the eligibility requirements for coverage under this Plan.

To opt-out of coverage under this provision, your spouse or dependent must complete the HSA Opt-Out election form which can be requested from the Plan Administrator.

Qualified Medical Child Support Orders (QMCSO)

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 Benefit Office, the Fund Administrator will promptly notify the eligible employee 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 defined in ERISA section 609(a). The Fund Administrator will determine whether the order is a QMCSO

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pursuant to the Plan's procedures, and notify the eligible employee and each alternate recipient of the determination. Any payment for benefits made by the Plan pursuant to a QMCSO in reimbursement for expenses paid by an alternate recipient's custodial parent or legal guardian will be made to the alternate recipient's custodial parent or legal guardian. Only Dependents who are eligible Dependents under this Plan can receive benefits. All benefits payable are subject to the rules of the Plan.

Family and Medical Leave Act (FMLA)

For eligible employees of certain large employers (50 or more employees), the Family and Medical Leave Act of 1993 (FMLA) creates a federal right for you to take up to 12 weeks of unpaid leave for your serious illness, after the birth or adoption of a child, or to care for your seriously ill spouse, parent or child. The Family and Medical Leave Act (FMLA) requires certain employers to maintain health care coverage during the leave period. If you qualify and take a family or medical leave, your eligibility for benefits is protected. Your employer is responsible for any required contributions and the Trustees will determine the contribution rate. If you think that you may qualify for a FMLA leave, contact your employer. Any dispute regarding your eligibility for a FMLA leave is between you and your employer.

Eligibility Upon Return from the Uniformed Services

The Uniformed Services Employment and Reemployment Act provides certain benefit protections to eligible employees on military leave in the uniformed services. You must be eligible for benefits when you enter active duty. If you enter active military service for up to 31 days, then you can continue medical, prescription, dental and vision coverage during that leave period if you continue to pay the required contributions or use available reserve funds for coverage. If you are in active military service for more than 31 days and your reserve funds have been exhausted, then you may be able to continue medical, dental and vision coverage at your own expense for up to 18 months. Contact the Benefit Office for further information.

Service in the uniformed services means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes:

- Active duty;
- Active duty for training;
- Initial active duty for training;
- Inactive duty training;
- Full-time national guard duty; and
- A period for which you are absent from a position of employment for an examination to determine your fitness for duty.

ELIGIBILITY

After you complete active duty, you must report to work with the union within the specified periods shown below. If you meet these requirements and register for work with the union, you will be covered on the first day of the month following the date of your honorable discharge or release from active duty, assuming applicable Dollar Bank, Sheet Metal #10 SAFE or self-payments are made to cover the cost of that coverage without meeting the 80-hour requalifying requirement.

If you were in military service	You must
1 to 30 days	Report to the union by the beginning of the first regularly scheduled workday after discharge (allowing eight hours for travel).
31 to 180 days	Submit an application for reemployment to a Contributing Employer and the union within 14 days after the completion of your service.
More than 180 days	Submit an application for reemployment to a Contributing Employer and the union within 90 days after the completion of your service.

The Benefit Office may request that you provide documentation to establish the timelines of your application for reemployment. Documentation may include a copy of your discharge papers that show the date of enlistment, the date of discharge, and whether the discharge was honorable.

Your coverage ends on the first day of the month following the date you enter uniformed services and elect not to continue coverage. Your eligible Dependents may continue coverage under the Plan by electing and making payments for COBRA Continuation Coverage.

When you are discharged, if you are hospitalized or recovering from a sickness or injury that was incurred during your military service, you have until the end of the federally prescribed period that is necessary for you to recover to return to or make yourself available for work with your employer (generally two years).

Termination of Eligibility

Collectively Bargained Employees

Your coverage will terminate on the last day of the third month following the last month in which sufficient contributions were reported to the Fund except in the case of Initial Eligibility. If you do not otherwise meet the eligibility requirements. For example, if the last month sufficient contributions were reported was February, then your coverage would terminate on the last day of May. Coverage will also end if you enlist with or enroll in coverage under the uniformed services of the United States, or if the Plan terminates.

EXAMPLE

IF THE LAST MONTH FOR WHICH CONTRIBUTIONS WERE REPORTED WAS JUNE, THEN YOUR COVERAGE WILL END ON SEPTEMBER 30 (ASSUMING YOU DON'T HAVE ANY DOLLAR BANK AVAILABLE FOR USE).

ELIGIBILITY

Continuation of Coverage

If you lose eligibility and if continuation coverage is available; then you have two options:

- The Plan's Special Continuation Coverage; or
- Coverage pursuant to the Consolidated Omnibus Budget Reconciliation act of 1985 (COBRA) (see pages 33-38).

COBRA benefits provided will be the same as under the active eligible employee Plan excluding the Death, Accidental Death and Dismemberment, and weekly sickness and accident benefits. Special Continuation Coverage benefits provided will be the same as under the active eligible employee Plan including the Death, Accidental Death and Dismemberment, and weekly sickness and accident benefits.

If you choose COBRA Continuation Coverage, then you are rejecting the Plan's Special Continuation Coverage. Similarly, an election of the Plan's Special Continuation Coverage is a rejection of COBRA Continuation Coverage. When you do not elect either type of continuation coverage, you will not be eligible for Plan coverage unless you return to work and reinstate your eligibility.

If you continue to work for an employer after that employer ceases to be a Contributing Employer, then you will not be eligible for either continuation coverage or COBRA coverage and any individual Dollar Bank will be forfeited.

Special Continuation Coverage

If your eligibility is terminated because the Fund has not received the required hours of contribution on your behalf and you do not have sufficient funds in your Dollar Bank, then you may make a maximum of 18 monthly self-contribution payments to maintain your Continued Eligibility. To do so, you must remain Actively at Work. If you are no longer working in the Sheet Metal trade, then you may continue coverage through COBRA if you qualify (see pages 33-38). Special Continuation Coverage is not available if you are retiring or entering a branch of the uniformed services.

<p>Actively at Work: The eligible employee is employed in, available for, or would be available for (except for being disabled) bargained or non-bargained work where contributions are required to be made to this fund.</p>
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You will forfeit your right to make self-contributions if you:

- Continue to do bargaining unit work at a job in the Sheet Metal trade, in the jurisdiction of the Union, for which no contributions are made or required to be made to the Fund on your behalf; or
- Become eligible for health coverage under another group Plan.
- An owner-member is ineligible for special continuation coverage.

Your Special Continuation Coverage will end on the earliest of the:

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- First day of the month for which you did not make the required contribution; or
- Last day of the 18th month for which you made self-contributions for the Special Continuation Coverage (in periods of high unemployment, the Trustees have the discretion to change the Special Continuation Coverage period to 36 months).

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

Disability Continuation Coverage

If your eligibility has been extended for the maximum time allowed under the special continuation rules, you can continue coverage if:

- You became totally disabled while eligible under the active eligible employees Plan;
- At least 11,500 hours of contributions were paid to the Plan on your behalf while performing covered employment; and
- You are receiving a pension benefit from either the Sheet Metal Workers Local #10 Pension Fund, Sheet Metal Local 10 Supplemental Retirement Fund, and/or the Sheet Metal Workers National Pension Fund.

You may self-pay for the above referenced disability continuation coverage until the later of the date you reach Age 65 or the date you become eligible for Medicare.

You can change from the disability continuation coverage to the retiree Plan at age 55 or older, if you meet the eligibility requirements for retiree benefits. Prior to age 55, you may change your coverage to the retiree Plan if you meet the other eligibility requirements, continue to be totally disabled and qualify for Medicare, or you continue to be totally disabled and earn less than \$1,500 per month, as verified by copies of your income tax returns. Contact the Benefit Office for more information on changing from disability continuation coverage to the retiree Plan.

Non-Bargained Unit Employees – Termination of Eligibility

If you lose eligibility due to your employment termination, you may continue medical, dental and vision coverage under COBRA only (see the description of COBRA coverage beginning on page 33).

If continuation coverage ends, you must meet the Initial Eligibility rules to be covered again.

Dependents

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

- The date your eligibility under the Plan terminates;

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- The date your Dependent no longer meets the definition of Dependent;
- The date your Dependent enters the uniformed services or enrolls in coverage under the United States; or
- The date the Plan terminates.

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

Special Dependent Continuation Coverage

If you die while covered under the Plan, coverage for your eligible Dependents will continue to your normal termination date as if you had remained alive and not earned any additional hours of contribution. Any funds remaining in your Dollar Bank may be applied toward the self-contributions required for continuation of Dependent coverage. Dependents will be eligible for extended coverage as long as they meet the definition of Dependent and they pay the required self-contributions when due. Your child born after your Death will be eligible as long as coverage for your other Dependents is effective. If your Dependent becomes eligible for other coverage, special Dependent continuation coverage terminates.

Your spouse may switch to retiree coverage when he or she reaches age 55. Your spouse's coverage will terminate the day he/she remarries. In this event, your Dependent children will be offered the right to continue coverage under COBRA Continuation Coverage.

Surviving Dependents must make the required self-contributions when they are due so that coverage remains continuous. Wilson-McShane Corporation 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 Wilson-McShane Corporation 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

In compliance with a federal law commonly called COBRA, this Plan offers its eligible employees and covered Dependents (called qualified beneficiaries) the opportunity to elect a temporary continuation (COBRA Continuation Coverage) of the Plan's healthcare coverage. This coverage includes medical, dental, prescription drug, vision, and hearing benefits when that coverage would otherwise end because of certain events (called qualifying events). Qualified beneficiaries who

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 an eligible employee and/or his Dependents who are covered under the Plan on the day before a qualifying event.

ELIGIBILITY

elect COBRA Continuation Coverage must pay for it. Death, AD&D, and weekly sickness and accident benefits are not covered under COBRA.

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 any eligible employee or Dependent of an eligible employee 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 Continuation 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 Benefit Office within 31 days after the date of marriage, birth, adoption, or placement for adoption.

COBRA Qualifying Events

A qualifying event triggers the opportunity to elect COBRA when you or your Dependent loses coverage under this Plan. Qualified beneficiaries are entitled to COBRA Continuation Coverage when qualifying events occur and cause coverage to end. If you or your Dependent has a qualifying event but do not lose healthcare coverage under this Plan, (for example, you continue working even though you are entitled to *Medicare*) then COBRA will not be available.

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

Qualifying event causing healthcare coverage to end	Maximum COBRA Continuation Coverage period for qualified beneficiaries		
	<i>Employee</i>	<i>Spouse</i>	<i>Dependent child(ren)</i>
Termination of employment (for other than gross misconduct)	18 months	18 months	18 months
Reduction in hours worked	18 months	18 months	18 months
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

Special Enrollment Rights

You have special enrollment rights that allow you to request special enrollment under another group health Plan for which you are otherwise eligible (such as a Plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of a qualifying event. The special enrollment right is also available to you if you continue cobra for the maximum time available to you.

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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. The 18-month period of COBRA Continuation Coverage may be extended for up to 11 months under certain circumstances (in cases of disability).

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 Benefit Office as listed in the *important contact information* section. **If notice is not received by the Benefit 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 Benefit Office will notify you and/or your covered **Dependents** of the date your coverage ends and the information and forms needed to elect COBRA Continuation Coverage when:

- Your employment terminated, your hours are reduced so that you are no longer entitled to coverage under the Plan, or you died; or
- You notify the Benefit Office that a Dependent is no longer eligible, you divorced, or you have become legally separated. *Note: failure to notify the Plan in a timely fashion may jeopardize you or your Dependent's rights to COBRA Continuation Coverage.*

You and/or 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, you and/or they will have no group health coverage from this Plan after the date coverage ends.

If you elect COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end (excluding short-term disability, life and AD&D insurance) but you 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 Benefit Office determines that you or your Dependent is not entitled to the requested COBRA Continuation Coverage, you 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.

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Paying for COBRA Continuation Coverage

You must pay the monthly contribution, as established by the Board of Trustees, for COBRA Continuation Coverage. You will be told the exact dollar charge for the COBRA Continuation Coverage that is in effect at the time you 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 Benefit Office 45 days after COBRA Continuation Coverage is elected. You will be billed for the month in which you lose eligibility. Your full payment must be received by the Benefit Office by the last day of the month for which the self-contribution is due. If payment is not received, COBRA Continuation Coverage will not take effect.

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.

If you miss a COBRA self-payment, you will lose COBRA Continuation Coverage.
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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 received after the deadline will not be accepted and your coverage will be terminated as of the first day of the month for which the self-contribution was due. **You will not receive a bill for COBRA after the initial notices and elections.**

Loss of Other Group Health Plan Coverage

If, while you are enrolled for COBRA Continuation Coverage, your Dependent loses coverage under another group health Plan, you may enroll your Dependent for coverage for the balance of the period of your COBRA Continuation Coverage. Your Dependent must have been eligible but not enrolled in coverage under the terms of Plan. In addition, when enrollment was previously offered under the Plan and declined, your Dependent must have been covered under another group health Plan or had other health insurance coverage.

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another Plan, termination because of loss of eligibility for the coverage, or termination because of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure to pay premiums on a timely basis or termination of coverage for cause. You must enroll your Dependent within 31 days after the termination of the other coverage.

Disability Extension of COBRA Continuation Coverage 18-Month Period Only

If you or your Dependent is determined by the social security administration to be disabled and you notify the Plan in a timely fashion, you and your Dependents 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

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and must last at least until the end of the 18-month period of COBRA Continuation Coverage. You must notify the Benefit 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 you or your Dependents experience another qualifying event while receiving 18 months of COBRA Continuation Coverage, 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;
- 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. You must notify the Benefit Office 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, you or your Dependent first becomes entitled to ***Medicare***;
- The date, after the date of the COBRA election, you or your Dependent first becomes covered under another group health Plan;
- During an extension of the maximum coverage period to 29 months due to the disability of you or your Dependent, 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

ELIGIBILITY

conversion coverage. The notice will be provided as soon as practicable after the Benefit Office determines that COBRA Continuation Coverage will terminate early.

Certification of Coverage When Coverage Ends

When your coverage ends, the Benefit Office will provide you and/or your covered Dependents with a certificate of creditable coverage that indicates the period of time you and/or they were covered under the Plan. The certificate will indicate the period of time you and/or 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 your group health coverage terminated.

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

RETIREE COVERAGE

Eligibility for Retirees – Collectively Bargained Employees

You will be eligible to receive benefits under the Retiree Plan if you retire and

- Make written application to the Board of Trustees no later than 31 days following the date your active coverage ends;
- Are eligible to receive a pension from the Sheet Metal Workers Local #10 Pension Fund, Sheet Metal Local 10 Supplemental Retirement Fund, and/or the Sheet Metal Workers National Pension Fund and/or the Production Sheet Metal Workers' Local 10 Retirement Plan;
- 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
- At the time of your application for coverage, and at any time thereafter, 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.

Note: if you don't meet the 11,500 hours requirement, you will not be eligible for Retiree Coverage.

If you cancel coverage due to lack of making a self-payment, and subsequently re-qualify for active coverage, then your hours towards meeting the 11,500 hour-requirement will start over at zero.

The Retiree Plan is described in a separate Summary Plan Description. If you elect coverage under Plan B, you are not eligible for subsidized coverage in the Retiree Plan. However, if you have 11,500 hours of continuous coverage under Plan B, you will be eligible for unsubsidized retiree coverage. Contact the Benefit Office for a copy of the Retiree Medical Benefits SPD.

Retirees Who Return from Service with the International Union

If you work for the International Union or a National or Regional Fund of another Sheet Metal-related entity, you will be placed on grace period status while in that employment. When you retire from that employment and meet all of the above requirements, including the 11,500 hour requirement which must have been met before you took other employment with one of the above noted entities, you will be able to resume participation in this Fund as a retiree with either the:

- Normal retirement benefits at the normal retirement rates; or
- Same benefits an active eligible employee receives except for life, AD&D, and Weekly Sickness and Accident Benefits. These benefits would be provided at the rates currently in effect for disabled individuals.

If you choose the active benefits as described above, you will have one opportunity, at a later date, to switch to the regular retirement coverage. If you choose the regular retiree coverage, then you will not get another opportunity to choose the active coverage.

RETIREE COVERAGE

Eligibility for Retirees – Non-Bargained Employees

Non-Bargained Employees are eligible for unsubsidized retiree benefits under different rules than collectively bargained employees. The retiree medical benefit SPD contains a description of these rules.

Active Opt-Out

In the event you cancel Active Eligible Employees' Plan coverage, normal Retiree Plan eligibility rules provide that the hours counted toward your 11,500 hours of contribution requirement will not be maintained and will return to zero if you regain eligibility under the Active Eligible Employees' Plan.

Effective January 1, 2010, you may exercise an Active Opt-Out. Active Opt-Out provides no Plan coverage during the opt-out period. However, by exercising the Active Opt-Out, you can "freeze" the number of hours you have accumulated toward the 11,500 hours of contribution requirement during the opt-out period, and begin accumulating contribution hours again once you have regained eligibility. To exercise this option, you must submit a monthly payment to the Plan to cover the monthly cost of the Early Retiree Subsidy Premium. The Plan determines the amount of the Early Retiree Subsidy on an annual basis, and it may increase or decrease from year to year. The following rules apply to the Active Opt-Out provision:

- You must continue to be available for work;
- You must have exhausted your individual dollar bank;
- You must pay the Early Retiree Subsidy Premium amount on a monthly basis;
- You may not use your SAFE account to pay the Early Retiree Subsidy Premium;
- Your payment must be received by the Plan on or before the first day of each month;
- You will not receive a monthly billing notice; and
- You may not revert to full Active coverage unless you return to work and re-qualify based on the Plan's Re-Qualifying Eligibility Rules which allow you to fully re-qualify at 145 hours or to self-pay the premium difference if you have worked 80 hours.

Retiree Opt-Out Rule – Other Coverage

As a Retiree with health coverage under the Plan you have the right to exercise an opt-out from coverage if you have other coverage available to you. Other health coverage could be coverage through your spouse, another employer, a State or Federal Exchange, the Veteran's Administration or other private insurance. You may want to consider this option as you approach the time you wish to retire as an active participant and transition your coverage to the Retiree Plan. Please note that you must maintain creditable coverage the entire time period that you have exercised the Retiree Opt-Out to have the ability to opt back into Retiree Coverage.

The Retiree Opt-Out is an independent option for you and your Dependents.

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

When you marry, your spouse is eligible for medical, dental, vision and prescription drug coverage as of the date of your marriage. Select contract areas offer single coverage and therefore conversion to family coverage will have a cost. Please take into consideration the two-month lag in work month to eligibility coverage month. Contact the Benefit Office for further information.

You must notify the Benefit Office within sixty (60) days of the date of your marriage to enroll your spouse. The fund will not pay any benefits on behalf of your spouse until you enroll your spouse for coverage. Once your spouse is enrolled, benefits will be paid retroactively back to the date of your marriage.

What You Need to Do

To enroll your spouse, complete the necessary enrollment form and return it to the Benefit Office within sixty (60) days of your marriage. Call the Benefit Office or visit the website to obtain the enrollment form.

Adding a Child

Your natural child will be eligible for coverage on the date of birth. If you adopt a child or have a child placed with you for adoption, he or she will be eligible for coverage on the date of placement as long as you are responsible for health care coverage and your child meets the Plan's definition of a Dependent child. Stepchildren are eligible for coverage on the date of your marriage.

What You Need to Do

You must notify the Benefit Office within sixty (60) days of (a) your natural child's date of birth, (b) your adopted child's date of placement, or (c) the date of your marriage (in the case of stepchildren) to add your child for coverage before the Fund will pay any benefits for that child.

Getting Legally Separated or Divorced

Upon legal separation or divorce, your spouse will no longer be eligible for coverage. Regardless of a court order requiring you to provide coverage for your ex-spouse, you may not continue to carry your ex-spouse as a Dependent on the Plan. However, a spouse may elect to continue coverage under the fund under COBRA.

In addition, you may be required to provide medical benefits for your child(ren) through a court order called a Qualified Medical Child Support Order (QMCSO), which is subject to Plan eligibility rules.

LIFE EVENTS

What You Need to Do

You or your spouse must notify the Benefit Office within sixty (60) days of the divorce or legal separation date for your spouse to obtain COBRA Continuation Coverage.

Please notify the Benefit 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 enters the military on a full-time basis or reaches the limiting age (see page 13 for a definition of Dependent).

Limiting age

Under the Plan, the limiting age for your Dependent child is:

- Age 26

If your child loses eligibility, your child may elect to continue coverage under COBRA.

What You Need to Do

You must notify the Benefit Office when your child is no longer eligible for coverage. You or your child must notify the Benefit Office within sixty (60) days of the date your child no longer meets the eligibility requirements of the Plan to obtain COBRA Continuation Coverage.

Taking a Family and Medical Leave of Absence

If you work for an employer with at least 50 employees, then you may be eligible for a Family and Medical Leave of Absence (FMLA). Your employer will have to determine if they are subject to the FMLA. The FMLA allows you to take up to 12 weeks of unpaid leave during any 12-month period due to:

If you and your spouse both work for the same employer, you and your spouse are eligible for a combined total of 12 weeks of leave during a 12-month period.

- The birth or adoption of a child or placement of a child with you for foster care or adoption;
- The care of a seriously ill spouse, parent, or child; or
- Your serious illness.

Your leave will end on the earlier of your return to work or 12 weeks. If you do not return to work within 12 weeks, you may qualify for COBRA Continuation Coverage (see pages 33-38).

The Fund will maintain your eligibility and medical coverage until the end of the leave, provided your employer properly grants the leave under the federal law and makes the required notification and payment to the Fund.

LIFE EVENTS

What You Need to Do

Contact your employer for more information relating to a leave under the FMLA.

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 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 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.

When you are discharged or released from military service, you have up to the USERRA specified period to register for work with the Union. If the union reports your registration for work to the Benefit Office during this period, your eligibility and your Dependents' eligibility will be reinstated (assuming you have a sufficient Dollar Bank reserve to provide coverage or you make required self-payments for the coverage month) to the day you registered for work. If you do not register for work within this period, you will be considered a new eligible employee and you will need to satisfy the re-qualifying eligibility requirements (see page 24).

<p>Reemployment</p> <p>Following your discharge from service, you may be eligible to apply for reemployment with your former employer in accordance with USERRA. Such reemployment includes your right to elect reinstatement in any existing health care coverage provided by your employer.</p>
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What You Need to Do

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

LIFE EVENTS

In the Event of Your Death

If you are eligible for coverage on the date of your death, your beneficiary will receive a Death Benefit as provided in the Schedule of Benefits. In addition, if your death is caused by an accident, your beneficiary will receive an Accidental Death and Dismemberment (AD&D Benefit).

What Your Beneficiary Needs to Do

Your beneficiary should contact the Benefit Office to make a claim. A certified copy of the Death Certificate is required. See the Death Benefit Section of this document for more information on how the Fund determines who the beneficiary is.

When You Leave Employment

You may elect to continue coverage through the Plan's Special Continuation Coverage (Collective Bargained Employees Only) or COBRA Continuation Coverage.

When You Retire

When you retire, coverage for you and your ***Dependents*** will end under the Active Eligible Employees' 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. You may be eligible for retiree coverage if you meet the eligibility requirements or you can elect COBRA Continuation Coverage.

When you retire, you may be able to:

- Use your dollar bank;
- Elect retiree coverage; or
- Elect COBRA Continuation Coverage.

If you are eligible for retiree coverage, you will receive more information when you retire.

Returning to Work

If your eligibility ended and you start working again for a Contributing Employer, you must once again meet the Requalifying Eligibility requirements described in the *Eligibility* section before you will be eligible for Plan benefits.

If you return to work following a military leave of absence, your coverage will be reinstated as described in the ***Taking a Military Leave*** section on page 43.

DEATH BENEFIT

Eligible Employees Only

The amount of the Death Benefit shown in the **Schedule of Benefits** will be paid to your designated beneficiary once the Benefit Office receives a certified copy of the Death Certificate.

You may change your beneficiary by filing a new form with the Benefit Office. Beneficiary designations are effective on the date the form is signed and filed with the Benefit Office. Whenever you complete a valid new beneficiary form, it revokes all earlier designations. If your beneficiary is a minor, payment of benefits will be subject to appropriate state law, including payment being made to the minor's legal guardian.

If your legal relationship with your designated beneficiary no longer exists at the time of your death, the beneficiary designation will be invalid. For example, if you name your spouse as beneficiary, but divorce prior to your death, that person would no longer be considered your beneficiary unless you updated your beneficiary designation and changed the relationship to "ex-spouse."

If there is no valid, named beneficiary on file at the time of your death, or if none of your beneficiaries are living at the time of your death, the Death Benefit will be paid equally to the surviving members of the first class listed below that applies to you.

Be sure your beneficiary designation is up to date.

1. Spouse; or, if none,
2. Children; or, if none,
3. Parents; or, if none,
4. Siblings; or, if none,
5. Estate.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Eligible Employees Only

If you die, lose a limb or lose your sight as the result of an accident, you (or your designated beneficiary) will receive the amount shown in the *Schedule of Benefits* on page 2. Dismemberment benefits are payable to you. Death benefits are payable to your designated beneficiary. The loss must occur within 90 days of the accident. No more than the amount shown in the *Schedule of Benefits* is payable if you sustain the loss of more than two limbs and/or sight in the same accident. This Accidental Death and Dismemberment benefit is in addition to any other benefits you or your beneficiary may receive from the Plan.

Severance must occur above the wrist joint or ankle joint. Loss of sight means the total and permanent loss of sight.

If there is no named beneficiary on file or none of your beneficiaries are living at the time of your death, the Accidental Death and Dismemberment benefit will be paid equally to the surviving members of the first class listed below that applies to your situation:

Be sure your beneficiary designation is up to date.

1. Your spouse;
2. Your children;
3. Your parents;
4. Your siblings; or
5. Your estate.

Exclusions

No benefits will be paid under this section for any losses caused by or contributed to by:

1. Bodily or mental infirmity (including the medical or surgical treatment of such a condition);
2. Disease or illness of any kind (including the medical or surgical treatment of such a condition);
3. Bacterial infection unless through a visible cut or wound;
4. The taking of drugs (except prescription drugs) or poison or asphyxiation from the inhaling of gas, when done on a voluntary basis; or,
5. Any of the general exclusions and limitations listed in this booklet.

WEEKLY SICKNESS AND ACCIDENT BENEFIT

Eligible Employees Only

After you become eligible for benefits, you may receive the weekly sickness and accident benefit for work absences resulting from a Non-Occupational Injury, Disease or Illness. Your benefit will begin on the first day of disability due to injury and on the eighth day of disability due to sickness. If an accident occurred more than 90 days prior to disability, that disability will be treated as a sickness. Payment for drug or alcohol related disabilities will be limited to a maximum of two periods of up to 30 days each per lifetime (and will be treated as a disease subject to payment of the benefit on the eighth day). A disability must be certified by a Physician operating within the scope of their license or a physician's assistant. However, a Doctor of Chiropractic (D.C.) or Nurse Practitioner may not certify a disability for you to receive this benefit. All references below to the care or treatment by a Physician are limited to this definition.

The amount of the weekly benefit is shown in the *Schedule of Benefits*. Applicable FICA Taxes will be deducted from this amount. The Fund will pay the employer portion of the FICA Taxes. There is no option to have federal or state income taxes from this payment, you should consult your professional tax adviser regarding this benefit. You will receive an IRS W2 for the applicable year payment was made.

All disability absences will be considered as having occurred during a single period of disability unless acceptable evidence is furnished that:

- The cause of the latest disability absence cannot be connected with the causes of any prior disability absences and the latest disability absence occurs after you returned to active work on a full-time basis for at least one day; or
- A connection with prior disabilities can be established but you returned to active work on a full-time basis for at least 10 consecutive workdays between such disabilities.

It is not necessary to be confined to your home to collect benefits. However, benefits are only payable for those days on which you are:

- Under the care of a Physician. A period of care will be considered to have started when you have been treated by the Physician; and
- Not performing work for compensation or profit.

You may not collect both state or federal unemployment insurance benefits and the weekly sickness and accident benefit for the same period.

In any rolling 12-month period, there will be a maximum of 26 weeks of sickness and accident benefits payable for absences related to the same illness or injury. After receiving the maximum 26 weeks of benefit, you must return to work for six months before becoming eligible to receive benefits for any related illness or injury.

You must inform the Claims Administrator if you return to covered work in any capacity.

WEEKLY SICKNESS AND ACCIDENT BENEFIT

Benefit for Partial Disability

During partial weeks of disability, your benefit will be paid at a daily rate of one-fifth (1/5) of the weekly benefit amount set forth in the *Schedule of Benefits*.

The Plan will also pay you a partial daily sickness and accident benefit if you are unable to work full days (minimum of six hours a day). You must receive at least one full week of weekly sickness and accident benefits immediately preceding your return to work for partial days (less than six hours per day). Your Physician must certify in writing that you can return to work.

The maximum benefit paid will be the difference between eight hours and the hours you actually worked each day (Monday through Friday). You will receive this benefit weekly after confirmation of the actual hours you worked and the hours available for you to work by your Contributing Employer.

Coordination of Benefits

This portion of the Plan has been designed to help you meet certain lost wages resulting from a disease, illness or injury. It is not intended that you receive greater benefits than are provided under this Plan, so the benefits under this Plan will be coordinated with the benefits from other Plans, including for example, employer sick pay policies and the like. Benefits payable by this Plan and any other Plans will not exceed 100% of the benefit provided by this Plan.

MAJOR MEDICAL EXPENSE BENEFIT

Eligible Employees and Dependents

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 80% of covered medical expenses, and your coinsurance is 20%, until you have reached your out-of-pocket maximum. Thereafter, the Plan pays 100% of covered medical expenses for the remainder of the Calendar Year.

Annual Out-of-Pocket Maximum

The 20% of covered medical expenses that you pay accumulate 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.

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.

MAJOR MEDICAL EXPENSE BENEFIT

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.

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*:

Outpatient Drug Testing Claims – Policy

Effective January 1, 2022, the Plan has adopted and incorporated by reference into the Plan the policy of Wilson-McShane Corporation regarding the Identification, Documentation, and Routing of Outpatient Drug Testing Claims Related to a Diagnosis of Substance Use Disorder for Medical Necessity Review. The policy is adopted to ensure parity of benefits being applied to mental health and substance use claims.

How Your Major Medical Benefits Are Paid

When the Plan receives a claim for a major medical service that has been provided to you, it will determine if the service is a covered benefit under the Plan. If the service *is not* a covered benefit, the claim will be denied and you will be responsible for paying the provider for these costs. If the service *is* a covered benefit under the Plan, the Plan will pay the claim. The amount the Plan pays is dependent upon whether the claim is In-Network or Out-of-Network.

In-Network Major Medical Claims

The Plan's medical network is provided through the UMR Choice Plus Network. If your claim is with a provider in the UMR Choice Plus Network, the Plan will pay the Reasonable and Customary Charge for the In-Network claim, minus any applicable copayments, deductibles or coinsurance that apply as provided in the Plan's Schedule of Benefits. If a network contract is in place, the network contract determines the Plan's Reasonable and Customary Charge.

Out-of-Network Major Medical Claims

If you receive covered services from a provider who is not participating within the UMR Choice Plus Network, the Plan will pay the Usual and Customary (U&C) amount for those services, minus any applicable copayments, deductibles or coinsurance that apply to the claim as provided in the Plan's Schedule of Benefits. Usual and Customary amounts are determined based on one of the following:

- Fee(s) that are negotiated by UMR with the Physician or facility; or
- The amount that is usually charged by health care providers in the same geographical area (or greater area, if necessary) for the same services, treatment based on the 80th percentile, or

MAJOR MEDICAL EXPENSE BENEFIT

- Using current publicly-available data reflecting the costs for health care providers providing the same or similar services, adjusted for geographical differences plus a margin factor.

The specific reimbursement formula used will vary depending upon the Physician or facility providing the service(s) and the type of service(s) received.

Self-Insured Plan

The Plan recommends you use In-Network providers whenever possible. Not only do you benefit by cost savings through the use of In-Network providers, but so does the Plan. The Plan is *your* self-insured health Plan that is funded by hourly contributions. This means that the Plan is not provided through an insurance company that charges a premium and bears the risk of the cost of claims. Rather, the Plan pays claims out of its own Plan assets funded by employer contributions made on your behalf and thus its financial standing is enhanced from the use of In-Network providers and the discounts received from such providers. Therefore, the Board of Trustees strongly encourages that you use such In-Network providers in seeking your medical benefits.

Notification of Benefit Determination

If a claim is submitted by a Participant or a Dependent, or a provider on behalf of a Participant, the Participant will receive an ExPlanation of Benefits (EOB) form that will explain how much the Plan paid toward the claim, and how much of the claim is the Participant's responsibility, if any, due to cost-sharing obligations, non-covered benefits, or other Plan provisions. Please check the information on each EOB form to make sure the services charged were actually received from the provider and that the information appears to be correct.

If you have questions or concerns about the EOB form, call the number listed on the EOB, the phone number listed on the back of the Plan's group health identification card or the Benefit Office. The provider will receive a similar form for each claim that is submitted.

Calculation of Major Medical Claims - Examples

Assuming you are covered by Coverage A, your annual deductible is \$145, your Annual Out-of-Pocket Maximum Benefit is \$1,160 and the amount you pay in coinsurance is 20%. If you are covered by Coverage B, see the Deductible and Out-of-Pocket Maximums in the Schedule of Benefits.

Calculation of In-Network Claim

When you have a claim for medical benefits that is In-Network, the billed charge on your medical claims will first be reduced by the significant In-Network Discount you and the Plan receive for using a provider in the UMR Choice Plus Network. After the discount is applied, and unless the particular medical services you have received require no cost-sharing, your claim will generally be paid as follows:

MAJOR MEDICAL EXPENSE BENEFIT

- First, you will pay your deductible, which under Coverage A is \$145. The Plan pays \$0 until you satisfy the deductible.
- Second, after you pay your deductible, the Plan will then pay 80% of the medical charges and you will pay 20%, which is your coinsurance.
- Third, you will pay 20% coinsurance until the claim is fully paid or you reach the Plan's \$1,160 Out-of-Pocket Maximum, whichever occurs first.
- Fourth, after you reach the Plan's Out-of-Pocket Maximum, the Plan will pay 100% of the remaining amount of the claim.

Below is an example of how a specific claim is paid *In-Network*:

In-Network Example: George fractures his leg. He experiences emergency room charges, diagnostic charges (x-ray), receives crutches (durable medical equipment) and rehabilitation services at an in-network provider.

In this example, George would pay:

Total Cost of Care (Billed Charge)	\$5,000
In-Network Charge for Care (Billed Charge less Network Discount)	\$2,800
Cost Sharing – George Pays	
Deductible	\$ 145
Copayments (Emergency Room)	\$ 50
Coinsurance (20%)	\$ 521
Total Out of Pocket for George (In-Network)	\$ 716

Calculation of Out-of-Network Claim

When you have a claim for medical benefits that is Out-of-Network, your claim will be calculated differently. First, because you did not use a provider in the UMR Choice Plus Network, the billed charge will be reduced by a much smaller Usual and Customary (U&C) reduction. After the U&C reduction is applied, and unless the particular medical services you have received require no cost-sharing, your claim will generally be paid as follows:

- First, you will pay your deductible, which under Coverage A is \$145. The Plan pays \$0 until you satisfy the deductible.
- Second, after you pay your deductible, the Plan will then pay 80% of the medical charges and you will pay 20%, which is your coinsurance.
- Third, you will pay 20% coinsurance until the claim is fully paid or you reach the Plan's \$1,160 Out-of-Pocket Maximum, whichever occurs first.
- However, even if you reach the Out-of-Pocket Maximum, you may still be balance billed and have to pay the difference between the original billed charge and the U&C reduction.

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Below is an example of how the same leg fracture detailed above would be paid *Out-of-Network*:

In this example, George would pay:

Total Cost of Care (Billed Charge)	\$5,000
Out-of-Network Charge for Care (Billed Charge less Usual & Customary Charge Reduction (-\$300))	\$4,700
Cost Sharing – George Pays	
Deductible	\$ 145
Copayments (Emergency Room)	\$ 50
Coinsurance (20%)	\$ 901
Plus	
Balance Bill Charge (Difference between the Billed Charge and Usual & Customary Charge Reduction)	\$ 300
Total Out of Pocket for George (Out-of-Network)	\$1,396

As the above examples illustrate, George would pay significantly less when using an In-Network provider.

The above are basic examples of how your claims are paid on an In- or Out-of-Network basis. You should contact Wilson-McShane if you have specific questions regarding how copayments, deductibles, coinsurance, and out-of-pocket maximums work for both In- and Out-of-Network major medical claims and for Coverages A and B.

Covered Major Medical Expenses

These medical services are covered by the Plan:

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 just room and board.
3. Charges for services rendered by Physicians and Mental Health Professionals.
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, unless provided at a licensed facility.

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5. Diagnostic laboratory and x-ray examinations. (See the *Schedule of Benefits* for information on medical imaging at Rayus which is covered at 100% after the deductible).
6. X-ray, radium, MRI, CT scans and radioactive isotope therapy.
7. Anesthetics, blood, blood plasma, and oxygen.
8. Durable Medical Equipment, subject to all of the following:
 - a. The equipment must meet the definition of Durable Medical Equipment in the Glossary of Terms.
 - b. Examples include, but are not limited to, crutches, wheelchairs, Hospital-type beds, and oxygen equipment.
 - c. The equipment must be prescribed by a Physician.
 - d. The equipment will be provided on a rental basis when available; however, such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied toward the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item.
 - e. The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair, or motorized scooter, unless necessary due to the growth of the person or if changes to the person's medical condition require a different product, as determined by the Plan.
 - f. If the equipment is purchased, benefits may be payable for subsequent repairs excluding batteries or replacement only if required:
 - i. Due to the growth or development of a Dependent Child;
 - ii. Because of a change in the Covered Person's physical condition; or
 - iii. Because of deterioration caused from normal wear and tear.
 - g. The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered, and replacement is subject to prior approval by the Plan.
 - h. This Plan covers taxes and shipping and handling charges for Durable Medical Equipment.

Durable Medical Equipment means equipment that meets all of the following criteria:

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- a. It can withstand repeated use.
- b. It is primarily used to serve a medical purpose with respect to an Illness or Injury.
- c. It is generally not useful to a person in the absence of an Illness or Injury.
- d. It is appropriate for use in the Covered Person's home.

A cochlear imPlant is not considered Durable Medical Equipment.

- 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. Payment for such covered charges 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.
- 11. Dental work or oral surgery for the prompt repair of natural teeth when required because of a Non-Occupational Injury or Disease. Expenses must be incurred within six months of the injury. This time period may be extended for a period of up to five years following the date of the accident, provided the eligible person submits a treatment Plan from his attending Physician or dentist with substantiation that the corrective treatment could not be completed within six months.
- 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.

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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 disease, other than a Mental Health Disorder.
17. Well baby immunizations (vaccinations) and Physician 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 as shown in the *Schedule of Benefits*, when ordered by a Physician, and only if the 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.

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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 calendar year.
23. Diagnosis, corrective orthopedic appliances, or surgical treatment of temporomandibular joint dysfunction (TMJ).
24. Hearing care, which includes one hearing examination per Calendar Year. Also included are hearing aid instrument(s) up to the maximum benefit shown in the *Schedule of Benefits*.

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 a 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;
 - 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;

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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.

28. Occupational 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. Bariatric surgery, subject to the following limitations:

a. Medically Necessary inpatient and outpatient services for bariatric surgery are limited to a lifetime coverage maximum of \$25,000; and

b. Prior authorization is required.

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

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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.

31. 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.

32. 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:

- a. Part-time or intermittent nursing care provided by a registered nurse or a licensed practical nurse supervised by a registered nurse;
- b. Part-time or intermittent home health aide services that consist primarily of medical care or therapy for the patient;
- c. 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

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- d. 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:

- a. Approved in writing and established by the attending Physician with the home health care provider; and
- b. Reviewed at least every 30 days.

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

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

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,
- 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 an itemized receipt to the Plan Administrator to receive the \$30 per night benefit.

PRESCRIPTION DRUG BENEFIT

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:

Brand Name Drugs: 20% of the cost of the prescription drug
Generic Drugs: 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.

Prime Therapeutics Broad Network

The Plan has adopted the Prime Therapeutics Broad Network of approved pharmacies which takes advantages of Prime Therapeutics strategic alliance with Walgreens. Therefore, to fill your prescription, you must go to a pharmacy in Prime's Broad Network.

The Broad Network includes all Walgreens pharmacies, many chain pharmacies as well as independent pharmacies. The Prime Broad Network excludes certain other national pharmacy chains such as CVS. This means you cannot use CVS or any other non-network pharmacy. It is important to remember this is your self-insured health Plan and the cost-savings realized from alliances such as this are significant in lowering pharmacy costs for you and all other Plan members. You can determine if your pharmacy is in the Broad Network by visiting www.MyPrime.com.

Prior Authorization

The Plan has implemented a prior authorization program applicable to certain subset of prescription drugs. Prior authorization is required on these medications before your prescription will be covered by

PRESCRIPTION DRUG BENEFIT

the Plan. If your prescription drug requires prior authorization, your physician must submit a prior authorization request form to Prime Therapeutics for approval.

- If authorization is granted, your prescription will be filled.
- If authorization is not granted, you have two choices:
 - You may still have the prescription filled by paying the entire retail cost of the prescription drug yourself; or
 - You may ask your doctor to prescribe an alternate drug covered by the Plan, if available.

To see a listing of drugs in the prior authorization program, visit www.MyPrime.com.

Quantity Level Limit Program

The Plan has implemented a quantity limit program for certain drugs based upon dosing limits established by the FDA. Quantity limits are applied to the number of units dispensed for each prescription. If there is a quantity limit for a specific drug you've been prescribed, and you need to exceed that quantity limit, your physician must submit a quantity limit override request form to Prime Therapeutics for a possible waiver of the quantity limit.

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 ID card.

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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 through ESI Home Delivery 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. ESI Home Delivery can be contacted at 1-833-715-0962.

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 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 through Accredo Specialty Pharmacy, 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. You can contact Accredo Specialty Pharmacy at 1-833-721-1622.

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 Benefit Office for a list of covered Specialty Drugs.

Manufacturer Copay Assistance Program

In addition to the above-noted Specialty Drug provisions, effective April 1, 2018, 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 receive a prescription for a Specialty Drug in the manufacturer copay assistance program, you must contact Accredo Specialty Pharmacy to fill the prescription. Accredo Specialty Pharmacy 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.

PRESCRIPTION DRUG BENEFIT

- 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 Accredo Specialty Pharmacy at 1-833-721-1622 to fill the Specialty Drug prescription.

If you have questions regarding the copay coupon program for Specialty Drugs, you can contact the Wilson-McShane at 952-854-0795.

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.

DENTAL CARE BENEFIT

Eligible Employees and Dependents

The Plan pays for Medically Necessary, Reasonable and Customary charges for dental services performed by a licensed dentist. Treatment must be according to generally accepted dental practice standards.

Deductible

The deductible is the amount of covered dental expense that you pay before the Plan pays the dental care benefit. The amount of your deductible is shown in the *Schedule of Benefits*. The deductible applies only once in any Calendar Year, and it applies to you and each of your eligible Dependents. The dental deductible is separate from the medical deductible.

Although each individual must satisfy a deductible, no more than the amount shown in the *Schedule of Benefits* as the family deductible will be applied in any Calendar Year for your entire family. Once three or more eligible family members together satisfy the family deductible, no other dental deductible will be applied for your family for the remainder of that Calendar Year. The deductible does not apply to Coverage A expenses.

Benefits Payable

After you have satisfied the deductible, the Plan applies the appropriate coinsurance for the covered dental expenses up to the maximums shown in the *Schedule of Benefits*. Note that Coverage D – orthodontic services has a separate lifetime maximum.

Covered Dental Expense

Covered dental expenses are the Reasonable and Customary charges for the following services and supplies:

Coverage A - Regular and Preventive Services

- Routine periodic examinations limited to two exams per Calendar Year, including bitewing x-rays at 12-month intervals. Pediatric preventive care will not be subject to a Calendar Year benefit maximum.
- Full mouth or panoramic x-rays once in any three-year period, unless special need is demonstrated.
- Dental prophylaxis, but not more than twice in a Calendar Year.
- Periodontal dental prophylaxis, but not more than twice in a Calendar Year.
- Topical fluoride applications, but not more than once in any 12 months.
- Dental sealant application.

DENTAL CARE BENEFIT

- Oral hygiene instruction, but not more than once in any 18 months.

Coverage B - Regular and Special Restorative Services

- Regular services, including:
 - Emergency treatment for relief of pain.
 - Amalgam, preformed crowns, synthetic porcelain, plastic and composite restorations.
 - Routine oral surgery for tooth removal including Pre-Operative and Post-Operative Care.
 - Endodontics, including pulpal therapy and root canal filling.
- Special services including:
 - Gold restorations when the teeth cannot be restored with another filling material.
 - Crowns and jackets when the teeth cannot be restored with a filling material.
 - Nonsurgical periodontics (procedures necessary for the treatment of diseases of the gums).
 - Surgical periodontics (the Surgical Procedures necessary for the treatment of diseases of the gums and bone supporting the teeth).
 - Any other oral surgery not previously mentioned.

Coverage C - Prosthetics (Removable and Fixed)

- Bridges.
- Partial dentures.
- Complete dentures.
- Crowns when used as abutments to a bridge.
- Replacement for an existing prosthetic appliance will not be provided more often than once in any five-year period, and then only in the event the existing appliance is not, and cannot be made satisfactory. This five-year period will be measured from the date on which the appliance was last supplied, whether under this Plan or not. Services necessary to make an appliance satisfactory will be provided, but will be treated as an expense under Coverage C. The term existing is intended to

DENTAL CARE BENEFIT

include an appliance that was placed at the beginning of the five-year period, but that, for whatever reason, is no longer in the possession of the patient.

The replacement of misplaced, lost, or stolen dental prosthetic appliances is not a covered dental expense.

Dental imPlants will be covered as an alternative to bridges or other prosthesis that would adequately restore the dental arch. The imPlant is covered up to the cost of a bridge and up to the corresponding coinsurance rate and maximums.

Coverage D - Orthodontic Services

- Covered dental expenses include the Reasonable and Customary charges for treatment necessary for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies.
- Coverage is not provided for the repair or replacement of any orthodontic appliance.

Payment of Orthodontic Benefits

Charges for orthodontic care do not become allowable until the services relating to such charges are actually rendered. However, if the program of treatment allots a single charge to the entire treatment period, then:

- If the treatment period is to last two years or less, one-eighth (1/8) of the entire charge will be considered to have been incurred on the day the first treatment is given and one-eighth (1/8) of the charge will be considered to have been incurred quarterly thereafter, to a maximum of eight quarterly payments; or
- If the treatment period is to last more than two years, the overall charge will be divided by the number of quarterly (three-month) periods in the expected treatment period. This divided charge will be considered to be incurred quarterly during the treatment period, the first such charge occurring on the day the first treatment is given and payment will continue until the maximum payment is made.

Exclusions and Limitations

The Dental Care Benefit is not payable for:

- Services performed for purely cosmetic purposes.
- Programs of treatment, including prosthetics, that were started before you became eligible for benefits from this Plan.
- Anesthesia, except by a dentist or by an employee of the dentist, when the anesthesia is administered in his office, in conjunction with covered services.

DENTAL CARE BENEFIT

- Services not specifically listed as covered dental expenses, including any Hospital charges or prescription drug charges.
- Services performed by someone other than a licensed dentist, the dentist's employees, or agents.
- Procedures, appliances, or restorations that are necessary to alter, restore, or maintain occlusion, but not limited to increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splitting and onathologic recordings. If these services are performed, cost responsibility will be yours, unless provided under orthodontic provisions of this benefit.
- Replacement of misplaced, lost, or stolen dental prosthetic appliances.
- Repair or replacement of any orthodontic appliances.
- Expenses incurred after eligibility ends, except for prosthetic devices that were fitted and ordered prior to termination and were delivered to you or your Dependent within 30 days after the date of termination.
- Prosthetic services (including bridges and crowns) started or under-way before you or your Dependent became eligible for benefits from this Plan.
- Dental services received from a dental or medical department maintained by or on behalf of a Contributing Employer, a mutual benefit association, Trustee, Plan fiduciary, or similar person or group.
- Dental expenses for which benefits are payable under the Major Medical Expense Benefit of this Plan.
- Services and appliances for the treatment of temporomandibular joint dysfunction (TMJ) other than by orthodontic care, as provided under Coverage D.
- Any of the circumstances listed in the General Exclusions and Limitations.

VISION CARE BENEFIT

Eligible Employees and Dependents

The Plan provides a discount Vision Care Benefit that is designed to reimburse you for a portion of the cost of eye examinations and glasses or other eyewear. The Vision Care Benefit will be paid up to the maximum shown in the *Schedule of Benefits* per two-year benefit period.

Covered Vision Care Expenses

Covered vision care expenses are charges for:

- Complete eye examination, including dilation of the pupil and/or relaxing of focusing muscles by drops, refraction for vision, and examination for pathology as performed by a legally qualified ophthalmologist or optometrist; and
- New or replacement frames and/or lenses (including contact lenses) prescribed by an ophthalmologist or optometrist, including the fitting cost of the supplier; or
- LASIK eye surgery-up to the lifetime maximum shown in the *Schedule of Benefits*.
- Natural lens replacement surgery subject to the *Schedule of Benefits* provision for LASIK eye surgery.
- Pediatric Preventive Care - one routine vision exam each Calendar Year, with no benefit year maximum.

An expense is considered to be incurred on the date on which the service was provided.

Benefit Maximum

The Plan will pay up to the amount shown in the *Schedule of Benefits* (see page 8) for the cost of covered services and supplies.

Limitations

Payment will not be made for:

- An examination not provided by, and lenses not prescribed by, an ophthalmologist (M.D.) or a licensed optometrist;
- Charges for services or supplies that are covered under any other section of this Plan;
- Special procedures, such as orthoptics or vision training, except as provided for under the Major Medical Benefit, and special supplies, such as non-prescription sun or safety glasses and subnormal vision aids;
- Visual analysis, which does not include refraction; or
- Medical or surgical treatment of the eye.

EMPLOYEE ASSISTANCE PROGRAM

Eligible Employees and Dependents

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:

Counseling services for:

- Alcohol and/or drug dependency
- Depression/Anxiety
- Behavioral Concerns
- Relationship Challenges
- Family and Parenting Issues
- Grief and Loss
- Stress Management
- Job Related Difficulties

Care Coordination Services to help:

- Schedule appointments
- Coordinate medical records
- Food resources
- Transportation resources
- Legal consultation
- Financial consultation.

The program is administered by TEAM Wellness at Work (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 in Edina and Duluth, Minnesota as well as Omaha, Nebraska and Pewaukee, Wisconsin. 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.

TOBACCO AND NICOTINE CESSATION BENEFIT

If you or your eligible Dependents use tobacco or nicotine and desire to quit, the Plan offers a tobacco and nicotine cessation support program to help you quit for good through UnitedHealthcare.

Call 1-800-207-7680 or register through the CARE App to get started on help quitting or reducing your use of nicotine products.

Once you've started you'll receive invitations for 1-on-1 coaching, educational materials tools to track progress as well as a six-week supply of nicotine replacement therapy (NRT) and access to the CARE App.

MATERNITY MANAGEMENT SUPPORT

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 contact UnitedHealthcare at 1-888-438-8105.

TELADOC

Teladoc 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. Teladoc provides you convenient access with board-certified doctors via phone or video within minutes for non-emergency, acute general medical needs. The Plan provides coverage for this benefit at 100%. There is no coinsurance or copayment required.

Teladoc may be used:

- When immediate care is needed.
- When considering the ER or Urgent Care center for non-Emergency issues.
- When you are on vacation or on a business trip.

Teladoc can be used for the following types of conditions:

- General medicine, including, but not limited to:
 - Colds and flu
 - Allergies
 - Bronchitis
 - Pink eye
 - Upper respiratory infections
- A refill of a recurring prescription.
- Pediatric care.
- Non-Emergency medical assistance.

In order to obtain this benefit, you must complete a medical history disclosure form that will serve as an electronic medical record for consulting Physicians. This form can be completed via the Teladoc website: www.Teladoc.com, via the call center, or via the Teladoc mobile app. Once enrolled, you may phone 1-800-TELADOC (1-800-835-2362) and request a consultation with a Physician. A Physician will return your phone call. If you request a web-based video consultation, the consultation will be scheduled and an appointment reminder notification will be sent prior to the appointed time. If necessary, the Physician will write a Prescription. The Prescription will be called in to a pharmacy of your choice. Benefits for this service are shown in the Schedule of Benefits.

The Teladoc app works with any smartphone, tablet or computer, with a front-facing camera. You can register your account by phone, web or mobile app. To get started, you can:

- Go to www.Teladochealth.com and click “Set up account”; or
- Download the Teladoc app from the App Store or Google Play and click “Active account,” or,
- Call 1-800-TELADOC (835-2362) and an account can be set up over the phone.

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. Hearing examinations required by an employer as a condition of employment or that the employer is required to provide by virtue of a labor agreement.
10. 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.
11. Services or supplies that are Experimental or Investigative or do not meet accepted standards of medical practice.
12. Medical expenses of a Dependent, other than a spouse, who is entitled to benefits as an eligible employee of a Contributing Employer. The Plan will be primary, but will coordinate as secondary.

GENERAL EXCLUSIONS AND LIMITATIONS

13. Specialty Drugs, except those purchased through the Specialty Drug program.
14. 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.
15. 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.
16. Charges for failure to keep a scheduled visit or charges for completion of a claim form.
17. 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.
18. 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).
19. 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.
20. Attorney's fees relating to Workers Compensation or personal injury proceedings.
21. Hospital charges for confinement following the time the attending Physician approves discharge from the Hospital.
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. Swimming programs and physical fitness programs other than at a Hospital outpatient department. Gym memberships are not a covered benefit.
24. Construction or a modification to a home, residence, or vehicle required because of an injury, illness, or disability.

GENERAL EXCLUSIONS AND LIMITATIONS

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. All medication, devices, or other methods used for smoking cessation, except as covered under the Smoking Cessation Benefit as detailed on page 71.
29. 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 geographic area, the Trustees will consider the geographic area where the covered individual normally would have received this type of medical treatment.
30. Chelation therapy, except for any expense or charges for chelation therapy for acute arsenic, gold, mercury, or lead poisoning.
31. Claims that are submitted 24 months or later after the service was performed.
32. Charges in excess of the Reasonable and Customary charge.
33. Recreational therapy.
34. Marriage counseling, except as provided directly by the Employee Assistance Program.
35. Acupuncture.
36. Unless otherwise covered under the Bariatric Surgery Benefits, medical or surgical treatment for weight reduction or obesity, including morbid or exogenous obesity. This exclusion includes, but is not limited to, dietary programs, surgical interventions or medications. 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.
37. Services from a Physician who does not meet the Plan's definition of Physician.
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

GENERAL EXCLUSIONS AND LIMITATIONS

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. 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.

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.

40. 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.
41. Inpatient out-of-network benefits (the Plan continues to cover Emergency Medical Conditions).
42. Compound drugs including those that contain bulk chemicals that are not FDA-approved, compound kits and pain patches.
43. Private-duty nursing.
44. Out-of-Network Telehealth.

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 to be 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 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. Contact the Benefit Office about how to file a claim for Death and Accidental Death and Dismemberment benefits.

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:

- Participant name;
- Patient name and date of birth;
- Social Security number of Participant; 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

BENEFIT CLAIMS AND APPEALS

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.

Where Claims Must Be Filed

United Healthcare (UHC) claims should be submitted to the local United Healthcare address 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, MN 55440-9474

Time of Payment of Claims

Claims other than for Weekly Sickness and Accident are paid as claims are submitted, providing the claims are complete. Weekly Sickness and Accident claims are paid every week, once written proof of the loss of time is received by Wilson-McShane Corporation.

Facility of Payment of Claims

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

If any claim is payable to the estate of the eligible employee 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 employee 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.

BENEFIT CLAIMS AND APPEALS

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 can obtain a form from Wilson-McShane Corporation 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.

Neither you nor your beneficiary may transfer or assign any life insurance benefit payments in anticipation of receiving them.

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 employee'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.

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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 Wilson-McShane Corporation 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.

Loss of Time Weekly Claims (Weekly Sickness and Accident Benefit)

For loss of time weekly claims, the Fund will make a decision on the claim and notify you of the decision within 45 days. If the Fund requires an extension of time due to matters beyond the control of the Fund, the Fund will notify you of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 45-day period. A decision will be made within 30 days of the time the Fund notifies you of the delay. The period for making a decision may be delayed an additional 30 days, provided the Fund Administrator notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of 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). Once you respond to the Fund's request for the information, you will be notified of the Fund's decision on the claim within 30 days.

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:

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- 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 and loss of time weekly claims that are denied due to:
 - Medical Necessity;
 - Experimental treatment; or
 - Similar exclusion or limit.
- If the claim is a disability claim, a description of the review process applicable to disability claims and a discussion of the decision including an explanation, if applicable, of the basis for disagreeing with or not following:
 - The views presented by your healthcare and vocational professionals;
 - The views of medical and/or vocational experts whose advice was obtained by the Plan in connection with this adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination; and
 - Your disability determination from the Social Security Administration.

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;

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- 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.

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, Weekly Sickness and Accident, Death, or AD&D 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.

BENEFIT CLAIMS AND APPEALS

- 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.

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.

If the decision involved disability benefits: you will receive a written exPlanation providing for the basis for disagreeing with or not following (1) the views presented by your health care and vocational professionals; (2) the views of medical and/or vocational experts whose advice was obtained by the Plan in connection with this adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (3) your disability determination from the Social Security Administration.

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.

BENEFIT CLAIMS AND APPEALS

No Surprises Act

Under the No Surprises Act, you will not be subject to surprise or balance billing when you receive the following types of care:

- Emergency care; or
- Treatment by an out-of-network provider at an in-network hospital or ambulatory surgical center.

Balance Billing (sometimes called “surprise billing”)

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn’t in the Plan’s United Healthcare Choice Plus Network.

“Out-of-network” describes providers and facilities that haven’t signed a provider agreement with the United Healthcare Choice Plus Network. Out-of-network providers may be permitted to bill you for the difference between what the Plan agreed to pay, and the full amount charged for a service. This is called “balance billing.” This amount is likely more than in-network costs for the same service.

“Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is the Plan’s in-network cost-sharing amount (such as copayments and coinsurance). You **can’t** be balance billed for these emergency services. This includes services you may get after you’re in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is the Plan’s in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can’t** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can’t** balance bill you, unless you give written consent and give up your protections.

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You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network and the Plan would strongly encourage you to seek care from providers in the United Healthcare Choice Plus Network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). The Plan will pay out-of-network providers and facilities directly.
- The Plan will:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what the Plan would pay an in-network provider or facility and show that amount in your exPlanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit under the Plan.

No Surprises Act Claims – Appeal Rights: Should you have a claim be denied for coverage or payment in the manner described above for emergency services or non-emergency services performed at an in-network facility by an out-of-network provider, you may appeal the matter to the Board of Trustees. Further, should the Board of Trustees deny the appeal, the above noted claims are subject to an External Third-Party Review as further provided below.

External Claim Appeals for No Surprises Act Claims Only

If the Board of Trustees denies your claim appeal involving a claim covered by the No Surprises Act, you may elect to have that adverse appeal determination reviewed by an External Third-Party Review.

Standard External Review for Non-Urgent Claim

You may file a request for an external review within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination.

1. Within five (5) business days following the date of receipt of the external review request, the Plan Administrator will complete a preliminary review of the request to determine whether:
 - a. You are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Plan at the

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time the health care item or service was provided;

- b. The adverse benefit determination or the final adverse benefit determination is not based on the fact that you were not eligible under the Plan;
 - c. You have exhausted the Plan's internal appeal process (unless exhaustion is not required); and
 - d. You have provided all the information and forms required to process an external review.
2. Within 1 business day after completion of the preliminary review, the Plan Administrator will notify you in writing regarding whether your claim is eligible for external review. To be eligible for external review, the adverse appeal decision must be based upon a medical judgment, or it must involve a rescission of coverage. If your request was not complete, the notice will describe information or materials needed to complete request. You will have until the end of the 4-month period you had to file a request for an external review or 48 hours (whichever is later) to complete your request. If your request is complete but not eligible for external review, the notice will include the reasons your request was ineligible and contact information for the Employee Benefits Security Administration.
3. If the request is complete and eligible for external review, the Plan Administrator will assign an accredited independent review organization (IRO) to conduct the external review.
- a. The IRO will utilize legal experts where appropriate to make coverage determinations under the Plan and will notify you in writing of the request's eligibility and acceptance for external review. You may submit additional information in writing to the IRO within 10 business days that the IRO must consider when conducting the external review.
 - b. The Plan Administrator will provide documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO.
 - c. The IRO will review all the information and documents timely received and is not bound by the Plan Administrator's prior determination. The IRO may consider the following in reaching a decision:
 - 1) Your medical records;
 - 2) The attending health care professional's recommendation;
 - 3) Reports from appropriate health care professionals and other documents submitted by the Plan Administrator, you, or your treating provider;
 - 4) The terms of the Plan;
 - 5) Evidence-based practice guidelines;
 - 6) Any applicable clinical review criteria developed and used by the Plan

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Administrator; and

- 7) The opinion of the IRO's clinical reviewer or reviewers after considering information noted above as appropriate.
- d. The IRO will provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision.

Expedited External Review

1. You may request an expedited external review when you receive:
 - a. An adverse benefit determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
 - b. A final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.
2. Immediately upon receipt of the request for expedited external review, the Plan Administrator will determine whether the request meets the reviewability requirements noted above for standard external review and will notify you of its eligibility determination.
3. When the Plan Administrator determines that your request is eligible for external review an IRO will be assigned. The Plan Administrator will provide all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO by any available expeditious method.
4. The IRO must consider the information or documents provided and is not bound by the Plan Administrator's prior determination. The IRO will provide notice of the final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the IRO's notice is not in writing, the IRO must provide written confirmation of the decision within 48 hours to the claimant and the Plan.

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Other Miscellaneous Legal Requirements

Genetic Information Nondiscrimination Act

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act.

Mental Health Parity and Addiction Equity Act

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act.

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).

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.

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;

PRIVACY POLICY

- 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;
- 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.

Health care 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.

PRIVACY POLICY

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

PRIVACY POLICY

- 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 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;
- 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;
- Any award of damages, whether by settlement, jury verdict, or court order, paid by any third party for injuries; or
- 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 its benefits and those paid by the primary Plan will not exceed 100% of allowable expenses.

COORDINATION WITH OTHER BENEFITS

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:

- 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 employee (father) determines benefits for Dependents before the Plan of the female employee (mother.)
- 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 active employees, Age 65 and older, this Plan will be primary. This means that you will first be reimbursed under this Plan and, if there are any expenses remaining unpaid, you will then be reimbursed for those expenses for which benefits are payable under Medicare. This also applies to a spouse of an active employee if both the employee and spouse are Age 65 or older.

Once you retire, even if you are continuing coverage under the Active Eligible Employees' Plan due to hours previously earned, this Plan will be secondary and Medicare will be primary.

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.

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 Office for assistance.

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

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.

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.

COORDINATION WITH MEDICARE

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 eligibility.

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 even if the person is also eligible for Medicare due to age.

SUBROGATION AND REIMBURSEMENT

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 held in trust for the Plan. The Plan then imposes a constructive trust or equitable lien on the recovery

SUBROGATION AND REIMBURSEMENT

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 you. 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 action (including in the subrogee's name) 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 AND REIMBURSEMENT

No Assignment: You cannot assign any rights or causes of action you 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 if you do 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 arises 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

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 are financed by employer contributions. The amount of employer contributions is based on a fixed rate per hour worked, which is determined by the provisions of the applicable collective bargaining agreements.

Plan Type

This Fund is maintained to provide Death, disability, Hospital, surgical, medical, dental and vision benefits for eligible employees 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 employees 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

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, MN 55109-2631
651-770-0991

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

As of October 1, 2024, 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

Jason Damman
Sheet Metal Workers' Local 10
1681 East Cope Avenue
Maplewood MN 55109

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

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

Colin Beere (Alternate)
Sheet Metal Workers' Local 10
1681 East Cope Avenue
Maplewood MN 55109

EMPLOYER TRUSTEES

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

Andy Graham
Modern Heating & Air
2318 First Street NE.
Minneapolis MN 55418

Rashid Kadir
Tessier's Inc.
218 East 1st Ave
Mitchell SD 57301

Casey Meinhardt (Alternate)
SMARCA, Inc.
1405 Lilac Drive No., Suite 100
Minneapolis, MN 55422-4598

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 (SPD) 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's fees.

STATEMENT OF ERISA RIGHTS

As a Participant in the Sheet Metal #10 Benefit Fund, 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 yourself, spouse, or Dependents if there is a loss of coverage under the Plan because of a qualifying event. You or your Dependents may have to pay for such coverage. Review this SPD 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.dol.gov/ebsa.

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>