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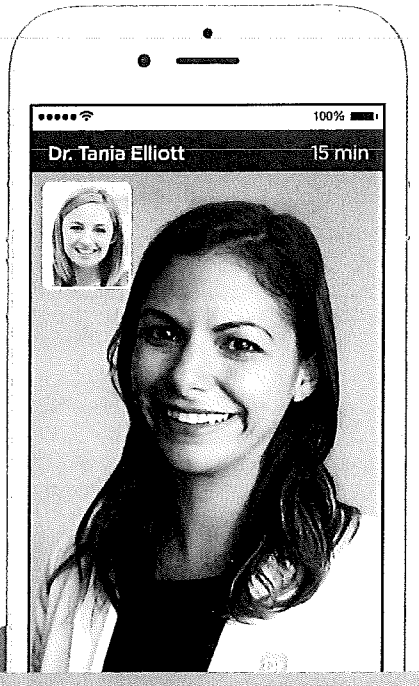

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*Doctor On Demand physicians do not prescribe Scheduled I-IV DEA Controlled Substances, and may elect not to treat or prescribe other medications based on what is clinically appropriate. Doctor On Demand is an independent company providing telehealth services. Doctor On Demand operates subject to state laws. As of 8/21/15, Doctor On Demand offers behavioral healthcare in all 50 states, and medical care in 47 states (not currently available in AK, AR and LA). Doctor On Demand is not intended to replace an annual, in-person visit with a primary care physician.

C3418 (12/15)

Sheet Metal #10 Benefit Fund

OFFICE OF THE ADMINISTRATOR
1681 East Cope Ave, Suite B, Maplewood, MN 55109
651-770-0991 Fax 651-770-1351 1-800-396-2903

January 2017

IMPORTANT ANNOUNCEMENT FOR RETIRED PARTICIPANTS

Summary of Material Modifications

The Trustees of the Sheet Metal #10 Benefit Fund announce the following change to the Plan for Retired Participants effective January 1, 2017.

1. Orthotics Benefit

The Plan is amended to provide for an increase in the orthotics benefit as provided in the Schedule of Benefits as indicated below. This change is effective January 1, 2017.

Orthotics Calendar Year Maximum Plan Coinsurance	 $300 per person 80% of Reasonable and Customary

2. Smoking Cessation – Page 8

The Plan has amended the Schedule of Benefits regarding Smoking Cessation Benefits to provide as follows:

Smoking Cessation (See Page 41) Nicotine Replacement Therapy Aids	100% reimbursement	100% reimbursement
Oral Prescription Medications	80% Name Brand 90% Generic	80% Name Brand 90% Generic

3. Smoking Cessation Benefits – Page 41

The Plan has amended its provisions with regard to Smoking Cessation Benefits on Page 41 to provide as follows:

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

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

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

4. Maternity Management – Page 41

The Plan has revised its provisions with regard "Healthy Start Prenatal Support" on Page 41. That section is now retitled "Maternity Management" and will provide as follows:

MATERNITY MANAGEMENT

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

Program Benefits:

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

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

5. Exclusion No. 41 – Page 44

The Plan has amended Exclusion No. 41 on page 44 to provide as follows:

41. All medication, devices or other methods used for smoking cessation except as covered under the Smoking Cessation Benefit as detailed on Page 41.

STATEMENT OF NONDISCRIMINATION

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The Fund provides free aids and services to people with disabilities to effectively communicate with us, 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, 800-537-7697 (TDD)

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

Minnesota/North Dakota/South Dakota Languages

Language	Translation
English	Attention: If you speak (insert language), language assistance services, free of charge, are available to you. Call 1-952-854-0795.
Spanish	Atención: Si usted habla (español), tenemos disponible para usted el servicio de ayuda en su idioma sin costo alguno. Llame al 1-952-854-0795.
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Cushite	Hubachiisa: Yoo kan afaan Oromoo dubbattan ta'e tajaajilli gargaarsa hiikoo afaanii ni argattu. Lakk. 1-952-854-0795 tiin bilbilaa.
Vietnamese	Nếu quý vị nói (tiếng Việt), chúng tôi có dịch vụ hỗ trợ ngôn ngữ sẵn sàng phục vụ quý vị miễn phí. Vui lòng gọi: 1-952-854-0795
Chinese	请注意：如果您讲中文，则您可以获得免费的语言协助服务。请致电：1-952-854-0795。
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Korean	참고: 한국어 지원 서비스를 무료로 제공합니다. 문의전화 1-952-854-0795

Tagalog

Attention: Kung nagsasalita ka ng (Tagalog), may magagamit kang mga libreng serbisyo sa wika. Tumawag sa 1-952-854-0795.

Notice Regarding "Grandfathered" Status

This notice must accompany any Plan materials that are sent to participants.

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; (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.

Sheet Metal #10 Benefit Fund

OFFICE OF THE ADMINISTRATOR
1681 East Cope Ave, Suite B, Maplewood, MN 55109
651-770-0991 Fax 651-770-1351 1-800-396-2903

October 2016

IMPORTANT ANNOUNCEMENT FOR RETIRED PARTICIPANTS

Summary of Material Modifications

The Trustees of the Sheet Metal #10 Benefit Fund announce the following changes to the Plan for Retired Participants. The changes are effective on the dates indicated below.

1. Nondiscrimination under Section 1557 of the Patient Protection and Affordable Care Act – Page 33

Effective January 1, 2017, the Plan is amended to add the following provision regarding Section 1557 of the Patient Protection and Affordable Care Act to Page 33.

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.

2. Exclusions No. 11 - Page 42

Effective January 1, 2017, the Plan is amended to revise exclusion No. 11 regarding Lifestyle and Cosmetic drugs to provide as follows:

11. 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 fifteen (15) unit doses per month per Participant.

3. Exclusion No. 24 – Page 43

Effective January 1, 2017, the Plan is amended to eliminate exclusion No. 24 regarding sex transformation.

24. Intentionally left blank.

4. Statement of Nondiscrimination – Page 60-61

Effective October 16, 2016, the Plan adds the following Page 88 regarding non-discrimination to the Plan.

STATEMENT OF NONDISCRIMINATION

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Sheet Metal #10 Benefit Fund

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1681 East Cope Ave, Suite B, Maplewood, MN 55109
651-770-0991 Fax 651-770-1351 1-800-396-2903

June 2016

IMPORTANT ANNOUNCEMENT FOR RETIRED PARTICIPANTS

Summary of Material Modifications

The Trustees of the Sheet Metal #10 Benefit Fund announce the following changes to the Plan for Retired Participants. The changes are effective on the dates indicated below.

1. In-Patient Out-of-Network – Page 7

Effective September 1, 2016, the Plan is amended to provide that there is no coverage for in-patient out-of-network benefits as further indicated through the revised Schedule of Benefits on Page 7:

Eligible Employees and Dependents Major Medical Expense Benefit	Coverage – Plan A	Coverage – Plan B
In-Patient In-Network Hospital Coverage	80% after annual deductible	80% after annual deductible
In-Patient 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
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

2. Lodging Benefit – Page 10

Effective April 1, 2016, the Plan is amended to add language regarding a Lodging Benefit to the Plan's Schedule of Benefits.

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:

- 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 (6) explanation of the necessity for daily proximity in order to participate in the lengthy medically necessary treatment program, and

- You must apply and receive approval from the Plan Administrator for this benefit prior to your medically necessary procedure.

- You must obtain lodging within the proximity of the medical facility as required by your attending physician.

- You must provide a receipt to the Plan Administrator to receive the $30 per night benefit.

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

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

Benefit Maximums

Maximum Daily Reimbursement	$30.00
Maximum Days Payable per Covered Person per Episode of Care	90 Days

3. Emergency Medical Condition Definition – Page 14

Effective September 1, 2016, the Plan is amended through the addition of a definition of Emergency Medical Condition which will provide as follows:

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

1. Placing the health of the individual (or with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy;

2. Serious dysfunction of any bodily organ or part; or

3. Serious impairment of bodily functions; or

4. With respect to a pregnant woman who is having contractions:

    a. That there is inadequate time to effect a safe transfer to another hospital before delivery, or

    b. That transfer may pose a threat to the health or safety of the woman or the unborn child.

4. Eligibility Rules for Retirees Who Retired on or After November 1, 1977 – Page 20

Effective February 1, 2016 the Eligibility Rules for Retirees who retired on or after November 1, 1977 are amended to provide as follows:

When You Retire

When you retire, coverage for you and your ***Dependents*** will end under the active Plan at the end of month with your last day worked unless you use dollar bank reserves to continue active coverage for a maximum of three months. You may exhaust the remainder of your bank for retiree coverage in this Plan. Additionally, you may use your SAFE Plan account balance to maintain coverage under this Plan. You may be eligible for retiree coverage if you meet the eligibility requirements or you can elect COBRA Continuation Coverage.

If you retired on or after November 1, 1977, you are eligible for coverage if you:

1. Made written application to the Board of Trustees within 31 days following the date of your active coverage under this Plan ends following your Date of Retirement. Date of Retirement" as used in this booklet means the day you voluntarily remove yourself from covered employment;

2. Are eligible to receive a pension from one of the following: the Sheet Metal Workers Local #10 Pension Fund, the Sheet Metal Local #10 Supplemental Retirement Fund, the Sheet Metal Workers National Pension Fund and/or the Production Sheet Metal Workers' Local 10 Retirement Plan; and

3. Had at least 11,500 hours of contributions paid to the Plan and/or to the former Rochester, Duluth and North Dakota Health and Welfare Plans on your behalf while you were an Active Employee. The 11,500 hours of service must occur immediately preceding retirement.

4. If you are a Non-Bargaining Unit Employee, then you must have eighty-two (82) months of coverage reported to the Fund before you retire.

5. 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.

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

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

5. Other Covered Expenses – Page 36

Effective September 1, 2016, the Plan is amended by deleting No. 1 on page 36 in its entirety and replacing with a new No. 1 which will provide as follows:

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).

6. Exclusions – Page 44

Effective September 1, 2016, the Plan is amended through the addition of the following exclusion which will provide as follows:

42. In-patient Out-of-Network Benefits (the Plan continues to cover Emergency Medical Conditions).

7. Subrogation and Reimbursement – Page 54.

Effective June 1, 2016 the Plan has amended its Subrogation and Reimbursement provisions to provide as follows:

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 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 Contructive 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 paragraph (b) above as well as the entirety of these subrogation provisions and the terms of the Plan as a whole, Subrogee's coverage under the Plan will terminate until such time as the Plan is made whole, including the reimbursement of all interest, attorney's fees and costs reasonably incurred. Only upon the Plan's being made whole may the Subrogee make application to the Board of Trustees of the Plan for reinstatement of their coverage.

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

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

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

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

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

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

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

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

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

Course and Scope of Employment: If the Plan has paid benefits for any injury which may have arisen out of and in the course and scope of employment, the Plan's right of subrogation and reimbursement will apply to all awards or settlements received by the Subrogee regardless of how the award or

settlement is characterized and regardless of whether the Plan has intervened in the action. If attorney's fees are awarded to the Subrogee's attorney from the Plan's recovery, the Subrogee will reimburse the Plan for the attorney's fees.

Notice Regarding "Grandfathered" Status

This notice must accompany any Plan materials that are sent to participants.

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; (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.

Sheet Metal #10 Benefit Fund

OFFICE OF THE ADMINISTRATOR
1681 East Cope Ave, Suite B, Maplewood, MN 55109
651-770-0991 Fax 651-770-1351 1-800-396-2903

June 15, 2016

Dear Sheet Metal #10 Benefit Fund participant,

The Trustees of the Sheet Metal #10 Benefit Fund look for ways to help manage health care costs.

Starting July 1, 2016, some medicines will become part of a **Prior Authorization (PA) program**. This means that your doctor will need to get an authorization before the drug will be covered. There are certain drugs that will require prior authorization. Generally they are specialty medications that are used to treat chronic illness and complex medical conditions. The following criteria is used to determine PA status:

- ✓ they may be harmful when combined with other drugs;
- ✓ should only be used for certain health conditions;
- ✓ are often misused or abused;
- ✓ may have dangerous side effects; and
- ✓ these drugs are expensive

The drugs that will now require a prior authorization are Esbriet, Hetlioz, Korlym, Kuvan, Juxtapid, Kynamro, Myalept, Natpara, Ofev, Subutex, Suboxone, Xenazine and Xyrem.

There is also a prior authorization program being implemented in which a new drug that comes to the market which could impact the Funds overall cost *could* require a prior authorization. This also would require your doctor to submit a request to get an authorization before the drug will be covered.

There is no immediate action required on your part. If you are prescribed one of these drugs (or others not listed in this letter) in the future, then you may need to talk to your doctor about your drug therapy options. Often, there are several medicines that can treat most common conditions.

If your medicine falls into this PA category and you and your doctor think your current medicine is the best choice for you, your doctor will need to submit a prior authorization (PA) request. Your doctor should include the medical reasons why he or she wants you to stay on your current medicine.

Your doctor can visit **www.bluecrossmn.com** to download a PA form. If authorized, the drug will be covered. The prior authorization (PA) procedures are listed below. Remember, treatment decisions are *always* between you and your doctor. Together, you can decide which medicine is right for you.

1. Patient/Member brings script into their pharmacy for processing
2. Drug rejects at point of sale and pharmacist advises patient to contact their doctor that a prior authorization is needed.
3. Doctor completes our form either on Cover My Meds (online PA tool) and submits electronically or fills out fax form and faxes request to 877-480-8130 (Prime Therapeutics). Information is on the form.
4. Once Prime Therapeutics receives the PA form from the doctor then the document goes through a process for approval or denial and your doctor or pharmacist will be informed.

If you have questions about your pharmacy benefit, please call Wilson McShane at 952-854-0795.

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May 2015

IMPORTANT ANNOUNCEMENT FOR ACTIVE AND RETIRED PARTICIPANTS

Summary of Material Modifications

The Trustees of the Sheet Metal #10 Benefit Fund announce the following changes to the Plan for Active Participants. The changes are effective on the dates indicated below.

1. Major Medical Expense Benefits – Active Page 51 #31, Retired Page 39 #32

Effective August 1, 2015, the Plan is amended to provide coverage for a prophylactic mastectomy and oophorectomy as follows:

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.

Notice Regarding "Grandfathered" Status

This notice must accompany any Plan materials that are sent to participants.

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; (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.

Sheet Metal #10 Benefit Fund

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October 2014

IMPORTANT ANNOUNCEMENT FOR RETIRED PARTICIPANTS

Summary of Material Modifications

The Trustees of the Sheet Metal #10 Benefit Fund announce the following changes to the Plan for Retired Participants. The changes are effective on the dates indicated below.

1. Annual Out-of-Pocket Maximum

In August 2013 the Plan issued an SMM for this Plan with regard to the Annual Out-of-Pocket Maximum. There was a typographical error in that provision. A corrected provision regarding the Annual Out-of-Pocket Maximum is provided below:

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	$980 per person $2,940 family maximum

2. Skilled Nursing Care – Page 8

Effective May 19, 2014, the Plan is amended to expand Skilled Nursing Care from 30 days to 90 days.

Skilled Nursing Care Daily Room and Board Confinement Maximum	100% of Reasonable and Customary 90 days; must have at least 60 days in between related confinements

3. Online Care Anywhere

Effective September 1, 2014, the Plan is amended to provide a benefit called "Online Care Anywhere." Online Care Anywhere is an online service available 24 hours a day, seven days a week that allows a covered person to visit a physician online from their home. Online Care is covered by the Fund at 100% not subject to the deductible.

To access and use the service, participant's must take the following steps:

1. Go to: www.OnlineCareAnywhereMN.com;
2. Register and enter their health summary;
3. Choose a doctor; and
4. Click connect.
5. Participants can also download the Online Care Anywhere app to their smart phone.

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

4. Prescription Drug Card Program – Page 34

Effective November 1, 2014, the following provisions are added to the end of the Prescription Drug Benefit Section on page 34:

> **Compound Drugs:** Certain compound drugs will be subject to prior authorization from the Plan's Pharmacy Benefit Manager Prime Therapeutics and will be excluded from coverage under the Plan unless determined to be Medically Necessary.
>
> The categories of compound drugs subject to this rule are: Musculoskeletal Therapy, Analgesics – Anti Inflammatory, Nasal Agents – Systemic and Topical, Anticonvulsants, Pain Agents, Ulcer Drugs, Skin Disorders and Addrogens.

5. Erectile Dysfunction Drugs – Page 42

Effective June 1, 2014, exclusion No. 11 on page 42 regarding erectile dysfunction drugs is amended to provide as follows:

> 14. Lifestyle and cosmetic drugs are not covered, except drugs prescribed specifically for the treatment of acne and erectile dysfunction drugs. Erectile dysfunction drug coverage is limited to fifteen (15) unit doses per month per Participant. However, erectile drugs in low dose form taken on daily basis, will not be subject to the above noted fifteen (15) day limit.

6. Retiree HRA Plan –

Effective January 1, 2015, the Plan has added a Retiree HRA Plan feature which will be added to the end of the SPD as an Appendix entitled "Retiree HRA Plan." The Retiree HRA Plan will provide as follows:

RETIREE HRA PLAN

Establishment of HRA feature to Plan

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

Legal Status

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

Definitions Applicable to Retiree HRA Plan

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

"Retiree HRA Account" means the HRA Account described under the "Establishment of Retiree HRA Account" section.

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

Eligibility to Participate

A Retiree is eligible to participate in the Retiree HRA as long as they meet the "Eligibility Rules for Retirees Who Retired on or After November 1, 1977" as detailed on page 20 of this Plan Document.

Conversion of Dollar Bank to Retiree HRA Account

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

Establishment of Retiree HRA Account

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

- *Crediting of Accounts.* The Retiree HRA Account will be credited with the dollar-for-dollar amount of the Retiree's Dollar Bank balance at the time of the Retiree's election for Retiree coverage.

- *Debiting of Accounts.* An Individual's Retiree HRA Account will be debited in the amount of the monthly premium required for Retiree coverage under this Plan only until such time as (1) the Retiree Opts-Out of coverage under the Sheet Metal #10 Benefit Fund for Retired Participants, (2) exhausts their Retiree HRA Account, or (3) otherwise loses coverage due to another provision of the Retiree Plan.

- *Available Amount.* The amount available for debiting of Retiree premiums from the Retiree HRA Account to the Sheet Metal #10 Benefit Fund for Retired Participants is the amount credited to an HRA Account reduced by prior monthly debits from the Retiree HRA Account to pay for coverage.

Eligible Retiree HRA Benefits

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

Termination of Participation

Retirees will have their Eligibility terminate pursuant to the "Termination of Eligibility" provisions on page 22 of this Plan Document.

Maximum Annual Benefit

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

If You Return to Active Employment

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

Spend Down/Forfeitures

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

Funding This Plan Feature

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

Notice Regarding "Grandfathered" Status

This notice must accompany any Plan materials that are sent to participants.

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; (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.

Sheet Metal #10 Benefit Fund

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651-770-0991 Fax 651-770-1351 1-800-396-2903

January 2014

IMPORTANT ANNOUNCEMENT FOR RETIRED PARTICIPANTS

Summary of Material Modifications

The Trustees of the Sheet Metal #10 Benefit Fund announce the following changes to the Plan for Retired Participants. These changes, in addition to those provided in the November 2013 Summary of Material Modifications are, in most instances, required by the Affordable Care Act and are enhancements of the benefits the Plan provides.

These changes are effective on the dates indicated below.

1. Change of Employee Assistance Program Provider from CIGNA to Total Employee Assistance Management, Inc. (T.E.A.M., Inc.)

Effective February 1, 2014, the Plan has changed Employee Assistance Program providers from CIGNA to Total Employee Assistance Management, Inc. (T.E.A.M., Inc.). The language on page 40 of the SPD will now provide as follows:

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 consultations, and support and educational materials for issues such as:

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

The Program is administered by Total Employee Assistance Management, Inc. (T.E.A.M., Inc.).

Several key points about this service:

- All Counseling by T.E.A.M., Inc 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.

T.E.A.M., Inc offices are located throughout the Twin Cities and confidential assistance is available 24 hours a day by calling: (651) 642-0182 or (800) 634-7710.

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

2. Retiree Opt-Out of Benefits

Effective December 1, 2013, the Plan has broadened its provisions allowing Retirees to opt-out of coverage under the Retiree Plan. Specifically, as a Retiree with coverage under the Plan you have the right to exercise an opt-out from coverage if you have other coverage available to you. Other coverage could be coverage through your spouse, another employer, a State or Federal Exchange, the Veteran's Administration or other private insurance.

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

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

Any available individual dollar bank or SAFE Fund balance will be "frozen" upon your electing to opt-out of coverage under the Plan and will be available for use should you later re-enroll in Retiree Coverage under the Plan.

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

3. Chiropractic Benefit

Effective January 1, 2014 the Plan has removed the twenty-five (25) annual visit maximum for Chiropractic Benefits. The Plan has retained the $30 maximum per visit payment.

The Schedule of Benefit will provide as follows:

Chiropractic Treatment Office Visit Maximum	80% after annual deductible up to a maximum of $30 per visit.	80% after annual deductible up to a maximum of $30 per visit.

4. Hearing Care (For Dependent under age 19 only)

Effective January 1, 2014 the Plan has amended its Hearing Care Benefit to provide that the maximum benefit provisions for the Plan's Hearing Care Benefit do not apply to Dependents under age 19.

The Schedule of Benefits will provide as follows:

Hearing Care Plan Coinsurance	80% of Reasonable and Customary	80% of Reasonable and Customary
Maximum Benefit For: One Examination Per Two Consecutive Calendar Years* Two Hearing Aid Instruments Per Five Consecutive Calendar Years*	 $150 $1,000 per hearing aid	 $150 $1,000 per hearing aid
*Maximum Benefit does not apply to individuals under age 19 (coinsurance does apply).		

5. Health Education – Page 3

Effective January 1, 2014, the Plan has amended its Health Education Benefit to eliminate the calendar year maximum.

The new schedule of benefits is provided below:

Health Education Plan Coinsurance	80% of Reasonable and Customary	80% of Reasonable and Customary
Lifetime Maximum	$6,000 per person	$6,000 per person

6. Definition of Dependent

Effective January 1, 2014 the Plan's definition of Dependent is amended to remove the language providing that Dependents under age 26 were ineligible for coverage if they were eligible for other employer provided coverage or if they were married and eligible to enroll in their spouse's coverage by virtue of the spouse's employment. As of January

1, 2014 any Dependent child under the age of 26 is eligible for coverage under the Plan. The definition of Dependent will now provide as follows:

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, including:

   A. A natural child, a lawfully adopted child, or a child placed for adoption (unless placement is disrupted prior to legal adoption and the child is removed from placement). Health evidence for the adopted child is not required.

   B. Either of the following in a regular 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. The QMCSO must be approved by the Plan. The Plan has adopted procedures for QMCSOs. These procedures are available upon request from the Fund Office.

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

Very Truly Yours

Board of Trustees

Notice Regarding "Grandfathered" Status

This notice must accompany any Plan materials that are sent to participants.

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; (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.

Sheet Metal #10 Benefit Fund

OFFICE OF THE ADMINISTRATOR
1681 East Cope Ave, Suite B, Maplewood, MN 55109
651-770-0991 Fax 651-770-1351 1-800-396-2903

November 2013

IMPORTANT ANNOUNCEMENT FOR ACTIVE and RETIRED PARTICIPANTS

Summary of Material Modifications

The Trustees of the Sheet Metal #10 Benefit Fund announce the following changes to the Plans for both Active Participants and Retired Participants. These changes are effective on the dates indicated below.

1. Dollar Banks

Effective September 1, 2013, the Plan has amended its Dollar Bank provisions on pages 22 and 23 of the Summary Plan Description through the addition of the following paragraph:

Dollar Bank Usage – Transition to 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 Fund Office of your desire to freeze your Dollar Bank.

2. Elimination of the Plan's Annual Limit.

Effective January 1, 2014, the Plan (Coverages A and B) has amended its Schedule of Benefits on page 2 to eliminate the Annual Maximum for Essential Health Benefits of $300,000 for Coverage in both Plan A and Plan B.

Effective January 1, 2014, the Retiree Plan has amended its Schedule of Benefits on page 6 to eliminate the $500,000 Annual Maximum Benefit for Essential Health Benefits for Retirees.

3. Elimination of the Pre-Existing Condition Exclusion

Effective January 1, 2014, the Plan has removed the Pre-Existing Condition definition on page 16 of the Summary Plan Description and the provisions regarding Pre-Existing Conditions on page 20 and 21 from the Plan for Active Participants. The Plan no longer has any pre-existing condition exclusions.

Prior to January 1, 2014, the Plan did have a pre-existing condition exclusion applicable to covered persons age 19 and older which provided that the Plan would pay a maximum of $10,000 during the first twelve months of coverage under the Plan.

4. Changes to the Plan's Exclusions – Voluntary Termination of Pregnancy

Effective January 1, 2014, the Plan has amended General Exclusion and Limitation No. 10 on Page 63 of the SPD for Active Participants to provide as follows:

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.

Summary of Benefits and Coverage

Included with this notice you will find your Summary of Benefits and Coverage (SBC) for 2014.

The SBC is required under the Patient Protection and Affordable Care Act (PPACA) and provides you with a summary of your benefits under the Plan. The SBC must be issued annually as well as any time the Plan makes a change that impacts the information contained in it. For example, you will note that the SBC reflects the change in item No. 2 above regarding the elimination of the Plan's annual maximum benefit.

This document is a summary of your benefits under the Plan. If you wish to more fully understand your benefits under the Plan you should refer to the Plan's Summary Plan Description (SPD) for full details.

Notice Regarding "Grandfathered" Status

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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; (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.

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651-770-0991 Fax 651-770-1351 1-800-396-2903

August 2013

IMPORTANT ANNOUNCEMENT FOR RETIRED PARTICIPANTS

Summary of Material Modifications

The Trustees of the Sheet Metal #10 Benefit Fund announce the following changes to the Plan's deductible and out-of-pocket maximum benefit which are effective on August 1, 2013.

1. Changes to the Plan's Deductibles

Effective August 1, 2013, the Plan has increased the deductibles for both individuals and families in the Schedule of Benefits as further indicated below:

Annual Deductible: Before the Plan pays for most covered expenses, you pay	$125 per person each year; $375 family maximum

Previously, the deductible for your coverage was $115/individual and $345/family

2. Changes to the Plan's Out-of-Pocket Maximums

Effective August 1, 2013, the Plan has increased the out-of-pocket maximum benefit for both individuals and families in the Schedule of Benefits as further indicated below:

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:	**Does not Apply to Mental Health and Substance Abuse Treatment and Pharmacy**
Individual Out-Of-Pocket Maximum	$980 per person
Family Out-Of-Pocket Maximum	$2,940 family maximum
Annual Out-Of-Pocket Maximum Does Not Include Your Deductible	

Previously, the out-of-pocket maximums were $900/individual and $2,700/family.

3. Orthotics Benefit

The Plan is amended to clarify that an orthotics benefit is provided in the Schedule of Benefits as indicated below. This change is effective February 1, 2013 and coincides with the issuance of the Summary Plan Description effective February 2013.

Orthotics	
Calendar Year Maximum	$100 per person
Plan Coinsurance	80% of Reasonable and Customary

Very Truly Yours,

Board of Trustees

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December 2012

Important Announcement for Active and Retired Participants

The Board of Trustees of the Sheet Metal #10 Benefit Fund are pleased to announce that they have made arrangements with the EPIC Hearing Service Plan to assist you in locating quality hearing care professionals and in most cases, reducing your out-of-pocket expenses for your hearing exams and hearing aid devices.

The EPIC Hearing Service Plan provides easy access to a national alliance of independent doctors of Otolaryngology and Audiology who can help you achieve your maximum hearing potential while also taking advantage of possible savings from 30-60% on name-brand hearing aids and products. The enclosed brochure describes the Hearing Service Plan in full detail.

As you know, the Sheet Metal #10 Benefit Fund provides a hearing care benefit at 80% for a maximum of $1,000 per hearing aid once per 5 calendar years. The EPIC Hearing Service Plan can help reduce your out-of-pocket cost and maximize your $1,000 hearing care benefit.

If you or your covered dependents are in need of a hearing evaluation or hearing aid, you can contact EPIC at their toll free number 1-866-956-5400 and identify yourself as a participant in the Sheet Metal #10 Benefit Fund. The EPIC Personnel will guide you through the process of hearing healthcare and you can obtain a referral to a provider in your area.

epic
HEARING HEALTH CARE

Sheet Metal #10 Benefit Fund

OFFICE OF THE ADMINISTRATOR
1681 East Cope Ave, Suite B, Maplewood, MN 55109
651-770-0991 Fax 651-770-1351 1-800-396-2903

May 2012

IMPORTANT ANNOUNCEMENT FOR RETIRED PARTICIPANTS

Summary of Material Modifications

The Trustees of the Sheet Metal #10 Benefit Fund announce the following changes to the Plan (Coverages A and B for Active and Retired Participants). These changes are effective on the dates indicated, below. Please read this notice and keep it with your Plan documents.

1. Changes to the Speech Therapy Benefit.

Effective **February 1, 2012**, the Plan (Coverages A and B for Active and Retired Participants) is amended to expand the Speech Therapy Benefit available under the Plan. Beginning February 1, 2012, the Plan will cover 80 percent of the reasonable and customary charges (after the annual deductible is satisfied) for speech therapy services incurred in relation to the treatment of:

- 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.

In addition, the covered speech therapy services must be provided by a qualified speech therapist, and the services must be ordered and monitored by a Physician pursuant to a written treatment plan for an identifiable clinical condition to be submitted and approved by the Plan. Progress reports 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. Speech therapy services are <u>not</u> covered if provided by a person who ordinarily resides in your home or who is a member of your immediate family (comprised of your spouse, your spouse's children, or your brothers, sisters and parents).

Previously, the Plan did not specifically cover speech therapy services related to the conditions listed, above, and speech therapy was limited to a maximum of 35 office visits. The Plan also did not specify by whom and under what circumstances covered services must be provided.

a. The Speech & Occupational Therapy portion of the Schedule of Benefits (p. 3) is deleted and replaced with the following:

Eligible Employees and Dependents		
Major Medical Expense Benefit	**COVERAGE – PLAN A**	**COVERAGE – PLAN B**
Speech & Occupational Therapy Visit Limit	80% after annual deductible up to a maximum of 35 visits.	80% after annual deductible up to a maximum of 35 visits.
Additional Speech Therapy Benefit for the treatment of: ▪ 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
Physical Therapy	80% after annual deductible.	80% after annual deductible.

These changes are effective for charges incurred for treatment occurring on or after February 1, 2012.

2. Expansion of Over the Counter Medication Coverage.

Effective **May 1, 2012**, Over the Counter (OTC) Fexofenadine (a substitute for Allegra), a non-sedating antihistamine, will be covered at 90% - your copayment is 10%.

The cost of this OTC medication is significantly less than brand name prescription drug Allegra, which also falls within the category of non-sedating antihistamine medications. OTC Fexofenadine is as safe and effective as the prescription version and, in fact, it was previously a prescription drug and became OTC within the last couple of years.

In order for this OTC medication to be covered by the Plan, you must take one of the following steps:

1) Ask your pharmacist to contact your doctor to change your existing prescription to OTC Fexofenadine, or

2) Get a prescription from your doctor for OTC Fexofenadine.

You must also present your Sheet Metal #10 Benefit Fund ID card at the pharmacy when purchasing OTC Fexofenadine.

If you follow the above procedures and go to a Prime Therapeutics network provider, you will only be responsible for the 10% copayment at the time of purchase.

Finally, remember your must show your **ID card** at the time you get your prescription if you want to pay only the copayments reflected above.

This change is effective for charges incurred on or after May 1, 2012.

Very Truly Yours,

Board of Trustees

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Notice Regarding "Grandfathered" Status

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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; (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.

Sheet Metal #10 Benefit Fund

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651-770-0991 Fax 651-770-1351 1-800-396-2903

December 2011

IMPORTANT ANNOUNCEMENT FOR RETIRED PARTICIPANTS

Summary of Material Modifications

The Trustees of the Sheet Metal #10 Benefit Fund announce the following changes to the Plans for Retired Participants. Please refer to the numbered items for an applicable effective date.

Please read this notice and keep it with your Plan documents.

Very Truly Yours,

Board of Trustees

1. Change to the Employee Assistance Program

Effective January 1, 2012, the Plan's Employee Assistance Program will be managed by CIGNA. **CIGNA is replacing T.E.A.M.,** Inc. as of that date.

Beginning on January 1st, you or your household members may contact CIGNA by calling 1-888-325-3978, or may sign onto their website (www.cignabehavioral.com) for free and confidential information regarding issues such as marital conflicts, legal or financial problems, alcohol or drug dependency, or spiritual or psychological counseling. On the login screen, you will need to enter the following *employer id*: sheetmetal10.

T.E.A.M. will no longer provide services for the Fund after December 31, 2011.

2. Changes to Comply with the Mental Health Parity and Addiction Equity Act of 2008

Effective January 1, 2012, several of the Plan's provisions are amended in order to comply with the requirements of a federal law known as the Mental Health Parity and Addiction Equity Act of 2008. In general, this law requires that a plan providing benefits for the treatment of mental health and substance use disorders may **not** limit those benefits differently than it limits benefits for medical and surgical treatment. In order to satisfy those requirements, the following changes are made to the Summary Plan Description.

a. The Mental Health and Substance Abuse Treatment portion of the Schedule of Benefits (on page 7) is deleted and replaced by the following chart.

Mental Health And Substance Use Treatment	Coverage
Inpatient – In or Out-of-Network	80%
Includes Partial Hospitalization and Day Care	
Subject to Major Medical Deductible and Out-of-Pocket Maximum	
Outpatient – In or Out-of Network	80%
Subject to Major Medical Deductible and Out-of-Pocket Maximum	

BEFORE and AFTER

Prior to this change, the Schedule of Benefits contained restrictions on the number of annual outpatient visits, the maximum length of an inpatient stay, and a lifetime maximum days of treatment for substance abuse. Those limits will no longer apply.

b. The Lifetime Maximum Benefits for Counseling and Bereavement Counseling under the Hospice Care Schedule of Benefits (page 8) are removed, as are all references to these maximums found in the description of Hospice Care on pages 38 and 39.

BEFORE and AFTER

Prior to this change, the Schedule of Benefits contained a lifetime maximums on the benefits available for Counseling relating to Hospice Care and Bereavement Counseling. Those limits will no longer apply.

c. The footnote on the bottom of page 7 is removed. It related to T.E.A.M., Inc. and certain treatment limits which have been removed from the Plan.

d. The Section entitled "Substance Abuse and Mental or Nervous Treatment (Active and Retiree Plans)" found on page 33 is deleted and replaced by the following:

Treatment of Mental Health Disorders and Substance Use Disorders

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

BEFORE and AFTER

Prior to this change, the Plan used different terminology to describe these treatments, and also referenced treatment limitations and benefit restrictions which will no longer apply.

e. The definition of "Mental or Nervous Disorder" on page 16 is deleted and replaced by the following:

Mental Health Disorder

Mental Health Disorder means a mental or behavioral disorder as defined in the 2010 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).

BEFORE and AFTER

Prior to the change, the Plan contained a definition of "Mental or Nervous Disorder". Federal law now requires a plan to provide an objective definition of "Mental Health Disorder." This is done by referencing a medical list of disorders. You can review this list at: http://apps.who.int/classifications/icd10/browse/2010/en#/V.

You will note from the definition, above, that certain disorders on the list are excluded from the Plan's definition of Mental Health Disorder. This includes blocks F10-F19 (which are included and covered as Substance Use Disorders, below), and blocks F-70 through F-89).

f. A definition of "Substance Use Disorder" is added to the Definitions section of the document, as follows:

Substance Use Disorder

Substance Use Disorder means a mental or behavioral disorder due to psychoactive substance use as defined in the 2010 International Classification of Diseases, Chapter V, Blocks F10 through F19.

BEFORE and AFTER

Prior to this change, the Plan did not contain a definition of "Substance Use" or "Substance Abuse." Federal law now requires a plan to provide an objective definition of "Substance Use." This is done by referencing a medical list of disorders. You can review this list at:
http://apps.who.int/classifications/icd10/browse/2010/en#/F10-F19

g. A definition of "Mental Health Professional" is added to the Definitions section of the document, as follows:

Mental Health Professional

Mental Health Professional means 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:

Psychiatric Nursing;
Clinical Social Work;
Psychology;
Psychiatry;
Licensed Professional Clinical Counseling; and
Certified Drug and Alcohol Counseling.

BEFORE and AFTER

Prior to this change, any mental health or substance abuse treatment needed to be ordered by a Physician. The plan has been revised to reflect that other health professionals may now provide such treatment.

h. The following entries are deleted from the list of General Exclusions beginning on page 41.

Exclusion #12
Exclusion #34
Exclusion #38
Exclusion #39

BEFORE and AFTER

This change removes from the Plan's list of General Exclusions certain restrictions on benefits which will no longer apply under this law. The changes are made so the provisions regarding treatment of Mental Health Disorders and Substance Use Disorders are consistent throughout the document.

3. Exclusion of coverage for charges relating to surrogate pregnancies

Effective October 1, 2011, the Plan is amended to exclude from coverage charges relating to surrogate pregnancies. The exclusion provides that benefits will not be paid under this Plan for charges relating to actual or attempted impregnation or fertilization involving an Eligible Employee, an Eligible Dependent, or a surrogate as a donor or recipient, extra-uterine conception, or the pregnancy of a surrogate mother. The 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.

4. Coverage of certain reconstructive surgery, including dental surgery

Effective October 1, 2011, the Plan is amended to provide that certain reconstructive surgery (whether medical or dental) will be covered under the Major Medical Expense Benefit portion of the Plan. To reflect these changes, the following revisions are made to the Plan:

a. Item 13 in the list of Other Covered Expenses (found on page 37 in the Retired Participants summary plan description) is removed and replaced by the following provisions:

13. Reconstructive surgery, including medical and dental services, provided as an integral part of a reconstructive treatment plan to restore and/or establish 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 an external force.

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

b. General Exclusion #40 found on page 44 of the Retired Participants summary plan description is deleted.

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651-770-0991 Fax 651-770-1351 1-800-396-2903

March 2011

IMPORTANT ANNOUNCEMENT FOR ACTIVE and RETIRED PARTICIPANTS

Summary of Material Modifications

Deductible and Out-of-Pocket Maximum
Effective May 1, 2011

In keeping with our goal as Trustees to provide all participants with the best health care coverage possible we continually balance claim expenses against Fund income, while doing whatever we can to manage costs so that your Health Fund remains financially viable and stable. At a recent Board meeting we reviewed current and projected expenses for the coming year and have determined that in order to achieve these goals it is necessary to increase Plan Deductibles and Out-of-Pocket Maximums.

We do not make these changes easily and we understand that it will have a financial impact on you, but these benefit changes still place the Fund's Deductible far below the market average of $500/$1,500 per individual/family. The following benefit changes will become effective with dates of service beginning May 1, 2011.

PLAN "A" (Actives and Retirees)

	Current		*New*	
	Individual	**Family**	**Individual**	**Family**
Deductible:	$100	$300	$115	$345
Out-of-Pocket Maximum:	$800	$2,400	$900	$2,700

PLAN "B"

	Current		*New*	
	Individual	**Family**	**Individual**	**Family**
Deductible:	$500	$1,500	**No Change**	**No Change**
Out-of-Pocket Maximum:	$1,500	$4,500	**No Change**	**No Change**

Active Opt-Out

You were previously sent a notice that informed you of the addition of an Active Opt-Out option benefit effective June 1, 2010. The Trustees have made a decision to change the effective date of this option to January 1, 2010. The provisions of this benefit are outlined below.

Effective January 1, 2010 you may exercise an Active-Opt-Out, which means you have **NO** Fund Coverage during the opt-out period. Fund Coverage includes medical, prescription, dental, vision, life and short term disability benefits. Exercising the Active-Opt-Out allows you to maintain your hour accumulator for the 11,500 hours requirement. To exercise this option, **you must submit a monthly payment** to the Fund to cover the monthly cost of the Early Retiree Subsidy Premium. The Fund will determine the amount of the Early Retiree Subsidy on an annual basis, and it may increase or decrease. The following rules apply to this 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 Fund on or before the first day of each month;
- You will NOT receive a monthly billing notice;

- 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; OR
- You can decide to enroll in Retiree coverage.
- During your Active-Opt-Out period, you will not have Fund Coverage. These benefits include medical, prescription, dental, vision, life, or short term disability. In addition, COBRA benefits will not be offered during or following the Active-Opt-Out period.

2010 Patient Protection and Affordable Care Act

The 2010 Patient Protection and Affordable Health Care Act, also known as "health care reform" requires certain changes to the Sheet Metal #10 Benefit Fund effective January 1, 2011. As the United States Department of Health and Human Services issues new guidance regarding these benefits, the Board of Trustees will modify and clarify the provisions of the plan required by changes due to the Patient Protection and Affordable Care Act.

Clarifications are as follows (effective for services on or after January 1, 2011 for both Plans A and Plan B):

For purposes of the benefits available under the Plan, the term "Pediatric" means birth up to Age 18. The following amendments to the Plan pertain to **preventative pediatric** vision care and oral care, as follows:

Vision Care (**pediatric preventative only**) coverage:

- One routine vision exam each calendar year, with no calendar year benefit maximum is covered under the plan of benefits.

Oral Care (**pediatric preventative only**) coverage:

Coverage for the following dental services will be provided in accordance with the Plan's current schedule of benefits, but will not be subject to the dental "calendar year benefit maximum"..

- Coverage A - Regular and Preventive Services
  - Routine periodic examinations limited to two exams per Calendar Year, including bitewing X-rays at 12 month intervals.
  - 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.
  - Topical fluoride applications, but not more than once in any 12 months.
  - Dental sealant application.
  - Oral hygiene instruction, but not more than once in any 18 months.

Very Truly Yours,

Board of Trustees

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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; (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.

Sheet Metal #10 Benefit Fund

OFFICE OF THE ADMINISTRATOR
1681 East Cope Ave, Suite B, Maplewood, MN 55109
651-770-0991 Fax 651-770-1351 1-800-396-2903

NOVEMBER 2010

IMPORTANT ANNOUNCEMENT FOR RETIRED PARTICIPANTS

Summary of Material Modifications

2010 Patient Protection and Affordable Care Act

The 2010 Patient Protection and Affordable Care Act, also known as "health care reform" requires certain changes to the Sheet Metal #10 Benefit Fund effective January 1, 2011. Changes due to the Affordable Care Act are as follows:

1. Dependent Children to Age 26 – Effective January 1, 2011

Currently dependent children are covered until age 19, or up to age 24 if attending an accredited school or college as a full time student. Effective 1/1/2011 due to the Affordable Care Act the Plan will extend coverage to children age nineteen (19) to twenty-six (26) regardless of whether they are a full time student, married, living at home, or financially dependent on the eligible employee.

Children who are eligible to enroll in an employer sponsored group health plan by virtue of their employment or, if married, by virtue of their spouse's employment are not eligible to be a dependent in this Plan. The spouse of a married child is not eligible to enroll in the Fund.

Even though the law allows all young adult dependents to be eligible for coverage under the Plan until age 26, if they lost or were denied coverage, **they must elect to enroll in the Plan in order to be covered.** A "Notice of Opportunity To Enroll and Application for Enrollment" is enclosed for individuals whose coverage ended or who were denied coverage (or were not eligible for coverage) because the availability of dependent coverage of children ended before attainment of age 26. To apply for enrollment/re-enrollment as an eligible dependent under the Plan, such individuals **must complete and return the form** to the Plan Administrator. The form can also be used to waive the offer to enroll. **Coverage commences only upon enrollment.**

2. Pre-Existing Condition Exclusion

The Affordable Care Act prohibits any pre-existing condition exclusions with respect to participants under the age of 19. No pre-existing condition clause contained in this Plan shall apply to participants under the age of 19 as of January 1, 2011.

3. **Annual Maximum Amounts Replaces Lifetime Maximum Amounts – Effective January 1, 2011**

The Affordable Care Act prohibits **lifetime** limits on the dollar value of benefits. Therefore, the current Major Medical Expense Benefit Lifetime Maximum of $500,000 will be eliminated. Effective January 1, 2011, all references in the Plan's Summary Plan Description to "Lifetime Maximum Benefit" are no longer valid. Effective this same date, the Plan has adopted an ***Annual** Maximum Benefit in the amount of $500,000.

Effective January 1, 2011, page 6 of the Schedule of Benefits will state:

Eligible Employees And Dependents Annual Major Medical Expense Benefit	Coverage
Annual Maximum	$500,000 for claims after January 1, 2003
Catastrophic Insurance Maximum	$15,000 per year
Once the Annual Maximum is reached, the Plan only provides assistance for catastrophic coverage up to $15,000 per year.	

*The Annual Maximum is contingent upon a grant of the Fund's Application for Waiver of Annual Maximum.

Pending before the United States Department of Health and Human Services is the Plan's request for a waiver of the Affordable Care Act's Annual maximum regulations, and the Plan has set for the 2011 Plan year the $500,000 Annual Maximum Benefit described above. The Plan will maintain its practice of paying for replacement coverage for persons who have met and exceeded the Annual Maximum Benefit. The maximum annual amount the Plan will pay for replacement coverage is $15,000.

Opportunity to enroll and application for enrollment
Because the lifetime limit on the dollar value of benefits under the Sheet Metal #10 Benefit Fund no longer applies, individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to re-enroll in the Plan. **Individuals have 30 days from the date of this notice to request re-enrollment.** Enrollment will be effective 1/1/2011. To apply for enrollment/re-enrollment as an eligible participant or dependent please contact the Plan Administrator at the address or phone number listed on this notice. The form can also be used to waive the offer to enroll.

4. **Annual Benefit Maximums for "essential health benefits"**

The Affordable Care Act also prohibits annual limits on the dollar value of benefits provided for "essential health benefits". Legal guidance has not yet been issued on what

constitutes "essential health benefits" so the Board of Trustees have made a good faith effort to comply with a reasonable interpretation based on the information that is available at the present time.

The following is a list of changes to the "essential benefits" that had an annual dollar value limit.

- Chiropractic Services: Visit payment limit of $30 and a visit limit of 25 visits per calendar year.

  Chiropractic X-Rays: Visit payment limit of $30 and a visit limit of 25 visits per calendar year (*combined with Chiropractic Services visits*).

- OP Occupational & Speech Therapy "Combined Benefit": 35 visits. No maximum dollar limit.

The following is a list of "non-essential" benefits which will remain unchanged.

- Hearing Aids: No Change, Consider as "non-essential"
- Orthotics: No Change, Consider as "non-essential"
- Health Education: No Change, Consider as "non-essential"
- Bariatric Surgery: No Change, Consider as "non-essential"
- Wigs: No Change, Consider as "non-essential"
- Dental: No Change, Consider as "non-essential"
- Vision: No Change, Consider as "non-essential"

Notice Regarding "Grandfathered" Status

This notice must accompany any Plan materials that are sent to participants

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NOVEMBER 2010

IMPORTANT ANNOUNCEMENT FOR ACTIVE AND RETIRED PARTICIPANTS

Summary of Material Modifications

1. **Physicians Neck & Back Clinics**

Due to the frequency and high cost of claims involving necks and backs, the Board of Trustee has added a preferred provider relationship with Physicians Neck & Back Clinics. Given the relatively low success rate of surgical intervention to cure chronic spinal pain, Physicians Neck and Back Clinics offer a non-surgical approach to spinal care for patients with chronic back and neck conditions. This program emphasizes aggressive muscle strengthening through the use of computerized equipment that isolates the most important muscles of the back and neck. The programs are customized to meet the specific therapeutic needs of the individual patient. The combination of proper equipment, knowledgeable supervision, and accurate data collection help to maximize the chances of a successful outcome.

If a Participant meets Physicians Neck and Back Clinics' selection criteria, then charges for its back and neck Rehabilitation Program will be covered at 100% subject to the annual deductible.

2. **Centers for Diagnostic Imaging – Effective January 1, 2011**

The health care decisions you face are important and it may be vital to have accurate and high quality imaging as part of any diagnostic process you may face. The Centers for Diagnostic Imaging is a group of outpatient centers that offers comprehensive diagnostic imaging (such as MRI's and CT scans), pain management, and radiology services. While many hospitals, clinics and doctor's offices have radiology equipment, Centers for Diagnostic Imaging offers the most advanced technologies, as well as highly specialized radiologists. The combination of advanced equipment and professional expertise are more likely to lead to an accurate diagnosis and are less likely to require repeat imaging procedures.

If a Participant obtains imaging or radiology services at a Centers for Diagnostic Imaging facility, then charges will be covered at 100% subject to the annual deductible.

3. 90dayRx Retail Program - Effective January 1, 2011

To help address the high cost of prescription drugs, the Board of Trustees introduces the 90dayRx retail program. If a participant has a chronic medical condition, it is likely they are taking long-term "maintenance" medications to improve health. The 90dayRx program helps the Participant and the Plan save money on maintenance medications with discount pricing and no dispensing fees when ordered on a three-month supply basis at certain retail pharmacies.

A Participant can refill prescriptions by mail and have them delivered to their residence, or go to a nearby participating pharmacy to be filled on the spot. The list of participating retain pharmacies is extensive and can be found at www.myprime.com or by calling 1-800-509-0545.

The prescription drug coverage benefit will remain as 10% co-pay for generic drugs and 20% for name brand drugs, however the discounts available through this 90dayRx program can be very significant. In addition the Participant can enjoy the convenience of filling a prescription once every three months rather than monthly.

Notice Regarding "Grandfathered" Status

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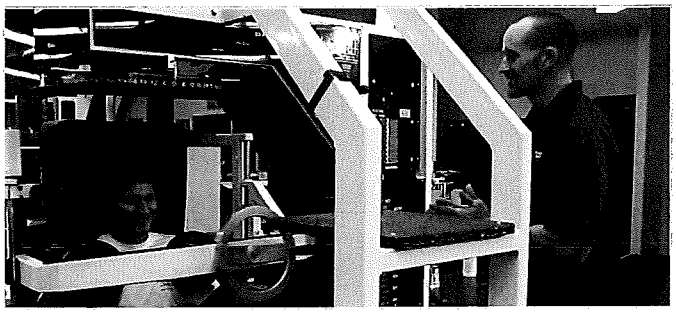
SHEET METAL #10 BENEFIT FUND

recommends Physicians Neck & Back Clinics and will **waive** your 20% coinsurance.

Who is PNBC?

PNBC is a leader in non-operative spine care.

PNBC staffs Board-certified medical doctors trained to treat chronic neck and back pain. Together, they work with highly trained rehab specialists to provide specialized treatment to a wide range of chronic neck and back pain.



What is the "Right" Treatment?

Did you know that only 2-3% of all patients with neck and/or back pain should get surgery?

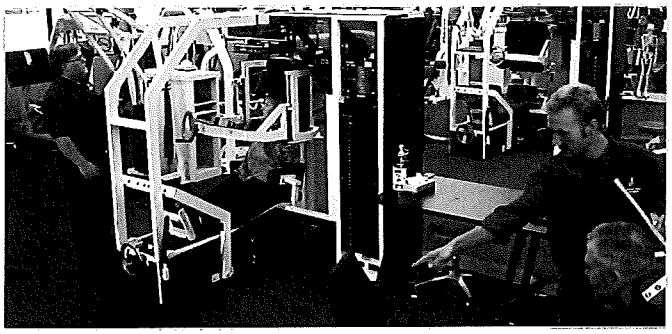
In a published study, 92% of patients who were referred for surgery did not need it after completing the PNBC program.

Before You Have Surgery...Visit PNBC

Many therapies are passive; they don't provide long lasting relief. And surgery may actually worsen your back. Instead, PNBC utilizes an exercise based program which strengthens the back and provides long term relief from back and neck pain.

PNBC emphasizes strengthening your body through the use of specialized equipment that isolates the most important muscles of the neck and back. The program takes 8-12 weeks to complete, and is customized to meet your specific needs. The goal of the program is to improve core strength, endurance, and mobility while restoring function and promoting physical independence.

For more information, call 651-735-2225 or visit ResumeActivity.com



Physicians Neck & Back Clinics

HealthPartners *Family of Care*

Our Clinic Locations

Coon Rapids
3440 129th Ave. NW

Edina
3601 Minnesota Dr.

Lakeville
17305 Cedar Ave.

Maple Grove
11671 Fountains Dr.

Roseville
3050 Center Pointe Dr.

Woodbury
1000 Radio Dr.

Sartell *(320) 253-5385*
158 19th St. S.

SHEET METAL #10 BENEFIT FUND

Recommends CDI & will WAIVE Your 20% Coinsurance

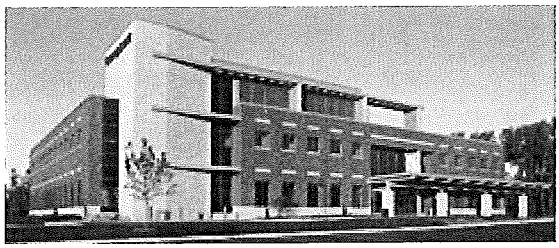
CENTER FOR DIAGNOSTIC IMAGING

Who is CDI?

CDI is a national network of imaging providers that offers a full range of diagnostic imaging, pain management, and interventional radiology services. Each CDI center is staffed by a local team of specialized physicians and associates who are connected with other CDI physicians across the country. This gives each CDI location the ability to share best practices and consult with other experts on special cases. **Patients receive local-individual care and the benefit of national resources under one roof.**

The CDI Experience

CDI centers are located in easy to find retail or medical mall areas. They provide ample free parking close to the front door, as well as convenient evening and weekend hours. In addition, CDI provides complimentary transportation from most areas for patients who are scheduled for an MRI, CT, diagnostic injection or pain management procedure. **When surveyed, 99% of their patients say they would refer CDI to a family member. Dedicated Labor Line Specialists are available at 866-765-7138 to work with you one-on-one to help answer your questions, provide easy scheduling, and help you become prepared for your exam.**



www.cdiradiology.com

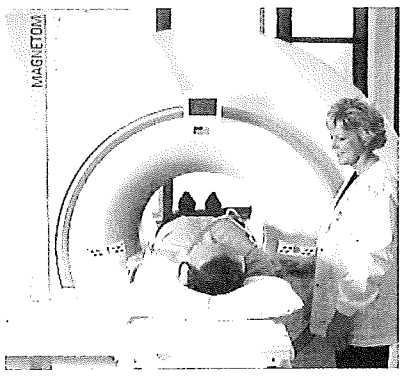
18 Diagnostic Center Locations:

- Alexandria
- Burnsville
- Coon Rapids
- Duluth (2)
- Eden PR. (2)
- Maple Grove
- Maplewood
- Mendota Hts.
- Minnetonka
- Sartell
- St. Cloud (2)
- St. Louis Park
- West St. Paul
- Willmar
- Woodbury

Advanced Technology

You Can't Diagnose What You Can't See

Imaging is critical to the diagnostic process and the quality of the image directly affects the accuracy of the diagnoses. CDI uses "high-field" MRI and other advanced imaging equipment whenever possible to provide higher quality images and more visible detail. To ensure the highest possible quality test results, every Radiologist at CDI has advanced training and exceptional knowledge in their chosen sub-specialty, (such as diagnostic injections, pain management procedures and exams involving the spine, brain, knees, etc,). CDI employs only board-certified technologists who play a crucial role in delivering the imaging services, while maintaining a safe and comfortable environment for their patients.



SHEET METAL #10 BENEFIT FUND

90dayRx *Save money at the pharmacy.*

Is the 90dayRX program right for you?

Save money every time you refill a prescription

Prescription drugs can be expensive. If you have a chronic medical condition, such as high cholesterol, asthma or diabetes, it is likely that you are taking long-term medications (*"maintenance medications"*) to improve your health. The 90dayRx program is a great way for **you and the Plan to save money** each time you refill your maintenance medications. 90dayRx lets you take advantage of special discount pricing, and no dispensing fees, at certain retail pharmacies when you order a three-month supply.

90dayRx gives you two ways to save

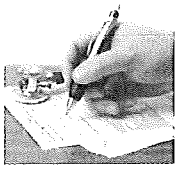
With the 90dayRX program, you decide how you'd like to receive your prescriptions.

- You can order your refills by mail and have them delivered right to your home.
- Or you can go to a participating neighborhood pharmacy and have them filled on the spot.
- To find a retail pharmacy closest to you, go to www.myprime.com.

How to use 90dayRx

At the pharmacy:

Step 1: If your maintenance medication is not currently being prescribed for a 90-day supply, ask your doctor to write your prescription for a 90-day supply. Or if you prefer, your pharmacist can ask your doctor to change your prescription to a 90-day supply.



Step 2: Go to a pharmacy that participates in the 90dayRx program. To find one near you, go to www.myprime.com (*from the drop down list chose BCBS Minnesota/Flex Rx Formula, then enter your Zip code*).

Home delivery:

Step 1: Ask your doctor to write your prescription for a 90-day supply.

Step 2: Get an order form online at www.myprime.com, click on the :"MyPrimeMail.com" Icon. Or you can also call 1-800-509-0545 if you have any questions.

Step 3: Fill out the order form and mail it with your prescription and payment to PrimeMail. You can then order refills online by going to www.myprime.com, or by calling **1-877-357-7463.**

Remember, the best way to save money on prescription drugs is to be an informed consumer.