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 2017

IMPORTANT ANNOUNCEMENT FOR ACTIVE PARTICIPANTS

Summary of Material Modifications

The Trustees of the Sheet Metal #10 Benefit Fund announce the following changes to the Plan for Active Participants.

1. Deductible – Page 2.

Effective September 1, 2017 the Plan's annual deductible provisions for Plan A are increased from $125 to $135 per person and from $345 to $405 per family. The Plan's annual deductible provisions for Plan B are increased from $545 per person to $600 and from $1,500 to $1,800 per family. The provisions on page 2 will now provide as follows:

Eligible Employees and Dependents Major Medical Expense Benefit *(See pages 44-51 for a listing of services covered as Major Medical Expenses)*	**Coverage – Plan A**	**Coverage – Plan B**
Annual Deductible Before the Plan pays for most covered expenses, you pay	$135 per person each year; $405 family maximum	$600 per person each year; $1,800 family maximum

2. Out of Pocket Maximum – Page 3.

Effective September 1, 2017 the Plan's annual out-of-pocket maximum provisions for Plan A are increased from $980 to $1,080 per person and from $2,940 to $3,240 per family. The Plan's annual out-of-pocket maximum provisions for Plan B are increased from $1,635 per person to $1,800 and from $4,905 to $5,400 per family. The provisions regarding out-of-pocket maximums on page 3 will now provide as follows:

Eligible Employees and Dependents Major Medical Expense Benefit *(See pages 44-51 for a listing of services covered as Major Medical Expenses)*	Coverage – Plan A	Coverage – Plan B
Annual Out-Of-Pocket Maximum Plan Pays 100% of Covered Charges for the remainder of the year, once you reach your Out-Of-Pocket Maximum: Individual Out-Of-Pocket Maximum Family Out-Of-Pocket Maximum Annual Out-Of-Pocket Maximum does not include your deductible	$1,080 per person $3,240 family maximum	$1,800 per person $5,400 family maximum

3. Doctor on Demand

The Plan is amended to replace the Online Care Anywhere program with Doctor on Demand, which will provide as follows:

Doctor on Demand

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

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

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

4. Prescription Drug Step Therapy Program – Page 52

The Sheet Metal #10 Benefit Fund has added a Step Therapy Program for certain medications. This program uses a "Step" approach to select the drugs the Plan will cover to treat your condition. This means you may first need to try a clinically appropriate, cost-effective drug before other more-costly drugs are approved for payment.

In step therapy, medications are grouped into categories:

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

If you are taking a 2nd Line medication immediately prior to implementation of this program, that specific prescription will be "grandfathered" and no action is required. However, if your prescription or dosage changes, you will need to discuss this Program with your doctor and choose a 1st Line medication that works best for you. If your doctor decides that you must use a 2nd line medication, then a Step Therapy Authorization form must be submitted by your doctor for approval. If the request is not approved, please remember that you may purchase the medication at your own expense.

The following is a list of current Step Therapy program names. Please note that this list is subject to change as the Trustees may add classifications based on the Fund's pharmacy benefit manager's review of Food and Drug Administration (FDA) labeling, nationally recognized drug treatment guidelines, and clinical evidence and research.

- Specialty Medications
- Fibromyalgia
- Antidepressant
- Atopic Dermatitis
- Antipsychotics
- Cholesterol
- Diabetes (GLP-1)
- Gastrointestinal-Proton Pump Inhibitors (PPIs)
- Hypertension
- Insomnia
- Multiple Sclerosis
- Pain Management NSAID
- Rheumatoid Arthritis/Psoriasis/Chron's

Please contact the Fund's pharmacy benefit manager at the number on the back of your ID card for further information.

STATEMENT OF NONDISCRIMINATION

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- Qualified sign interpreters
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- 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.
Hmong	Faj Seeb: Yog hais tias koj hais (Hmoob), kev pab cuam pab txhais lus, dawb tsis tau them, yeej muaj muab rau koj. Hu 1-952854-0795.
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。
Russian	Внимание: Если Вы говорите на (Русском), услуги лингвистической поддержки доступны Вам бесплатно. Звоните 1-952-854-0795.
Laotian	ໝາຍເຫດ: ຖ້າທ່ານເວົ້າພາສາລາວ, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. ໂທຫາ 1-952-854-0795.
Amharic	ማሳሰቢያ: የሚገሩት (አማርኛ) ቋንቋ ከሆነ ከክፍያ ነጻ የሆነ የቋንቋ እገዛ አገልግሎት ማግኘት ይችላሉ። በስልክ ቁጥር 1-952-854-0795 ይደውሉ።
Karen	w>'k;oh.ng=erh>uwdR (unDusdm)< usdmw>rRpXRw>zH;w>rRwz.< vXwvXmbl;vJ< td.vXe*D>M.vDRI ud;vD wJpdql 1-952-854-0795 wuh>I
German	Hinweis: Wenn Sie (Deutsche) sprechen, stehen Ihnen kostenlose Sprachhilfsdienste zur Verfügung. Rufen Sie unter 1-952-854-0795 an.

Cambodian	ចំណាំ៖ ប្រសិនបើអ្នកនិយាយ (ភាសាខ្មែរ) សេវាកម្មជំនួយខាងភាសាដោយឥតគិតថ្លៃនឹងមានសម្រាប់អ្នក។ សូម ទូរស័ព្ទទៅកាន់ 1-952-854-0795 ។
Arabic	ملاحظة: إذا كنت تتحدث (العربية)، فيرجى العلم بأنه يمكنك الاستفادة من خدمات المساعدة اللغوية مجانًا. اتصل بالرقم: 1-952-854-0795.
French	Attention : Si vous parlez (Français), des services langagiers vous sont offerts gratuitement. Veuillez composez le 1-952-854-0795.
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

May 1, 2017

Dear Sheet Metal Worker;

As a Sheet Metal Worker in a specific Sheet Metal Workers International Association, Local #10 area, you may have expanded choices regarding your participation in the Sheet Metal Workers #10 Benefit Fund ("the Fund"). Depending on your employment classification, you may have the choice of a lower-cost, reduced benefit option, as well as the opportunity to choose either single or family coverage.

Lower Cost/Reduced Benefit Plan Option, Plan B:

Effective October 1, 2006, a reduced benefit medical plan with a lower hourly contribution rate became available, and it is known as Plan B. The regular Fund coverage described in the Summary Plan Description is Plan A. Plan B options may be available to you depending on your employment classification. You will need to refer to the applicable wage/fringe for your area to determine your Plan B options available to Journeymen, Apprentices, Pre-Apprentices etc.

Electing Plan B vs. Plan A has significant implications. The following table summarizes the Plan B benefits as compared to the current Plan (Plan A).

	Plan A	**Plan B**
Annual Deductible	$125 per Individual $375 per Family	$545 per Individual $1,635 per Family
Annual Out-of-Pocket Maximum	$980 per Individual $2,940 per Family	$1,635 per Individual $4,905 per Family
Weekly Accident & Sickness Benefits	Included	**Not** Included for 10/1/06-4/30/2009 **Included after 5/1/2009**
Subsidized Retiree Coverage	**Included**	**Not included**

All other Plan A benefits and rules are in Plan B.

Single / Family Coverage Option:

All classifications of employment will have the opportunity to elect Single Coverage or Family Coverage:

- Any reduction in hourly contribution will result in a corresponding increase or decrease in your taxable base pay, but will not change your current total wage and benefit package.
- For other classifications of employment, the employer will contribute the hourly contribution for Plan B Single Coverage . You will have the opportunity to elect a base salary reduction for Family Coverage.

If you elect Plan B, the difference in the hourly contribution for Family Coverage is NOT taxable to you, but will result in a lower taxable base.

Hourly Contribution Rates:

The Plan A and Plan B option(s) available to you are outlined above. The hourly employer contribution rates for each level of coverage are as follows:

	Plan A	Plan B
Single Coverage	$8.16*	$3.24**
Family Coverage	$9.66*	$7.44**

* Plan A: The $1.50 difference between single coverage ($8.16) and family coverage ($9.66) will be paid as an increase in the taxable base which **IS** taxable to you.

** Plan B: The $4.20 difference between single coverage ($3.24) and family coverage ($7.44) will be paid by you as a reduction in the taxable base which is **NOT** taxable to you.

You may elect a change to either Plan A or Plan B upon an Event as defined in the Summary Plan Description, or upon the annual Open Enrollment period which is from November 1 through November 30 for effective date of January 1. It is very important to fully understand how an election choice for either Plan A or Plan B affects you and your family.

Please call the Fund Office at 651-770-0991 or 1-800-396-2903 if you have any questions regarding this information.

Sincerely,

Sheet Metal #10 Benefit Fund

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 ACTIVE PARTICIPANTS

Summary of Material Modifications

The Trustees of the Sheet Metal #10 Benefit Fund announce the following change to the Plan for Active Participants. The change is effective on the date indicated below.

1. Orthotics Benefit

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

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

2. Smoking Cessation – Page 4

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

Smoking Cessation (See Page 61)		
Nicotine Replacement Therapy Aids	100% reimbursement	100% reimbursement
Oral Prescription Medications	80% Name Brand 90% Generic	80% Name Brand 90% Generic

3. Smoking Cessation Benefit – Page 61

The Plan has amended its provisions with regard to Smoking Cessation Benefits on Page 61 to provide as follows:

SMOKING CESSATION BENEFIT

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

Nicotine Replacement Therapy Aids: Purchase over the counter nicotine therapy replacement quit aids and submit your receipts to Wilson-McShane 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 62

The Plan has revised its provisions with regard "Healthy Start Prenatal Support" on Page 62. 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. 29 – Page 65

The Plan has amended Exclusion No. 29 on page 65 to provide as follows:

29. All medication, devices or other methods used for smoking cessation except as covered under the Smoking Cessation Benefit as detailed on Page 61.

STATEMENT OF NONDISCRIMINATION

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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

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Hmong	Faj Seeb: Yog hais tias koj hais (Hmoob), kev pab cuam pab txhais lus, dawb tsis tau them, yeej muaj muab rau koj. Hu 1-952854-0795.
Cushite	Hubachiisa: Yoo kan afaan Oromoo dubbattan ta'e tajaajilli gargaarsa hiikoo afaanii ni argattu. Lakk. 1-952-854-0795 tiin bilbilaa.
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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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Laotian	ໝາຍເຫດ: ຖ້າທ່ານເວົ້າພາສາລາວ, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. ໂທຫາ 1-952-854-0795.
Amharic	ማሰሰቢያ: የሚገሩት (አሚኛ) ቋንቋ ከሆነ ከክፍያ ነጻ የሆነ የቋንቋ እገዛ አገልግሎት ማግኘት ይችላሉ። በስልክ ቁጥር 1-952-854-0795 ይደውሉ።
Karen	w>'k;oh.ng=erh>uwdR (unDusdm)< usdmw>rRpXRw>zH;w>rRwz.< vXwvXmbl;vJ< td.vXe*D>M.vDRI ud;vD wJpdql 1-952-854-0795 wuh>I
German	Hinweis: Wenn Sie (Deutsche) sprechen, stehen Ihnen kostenlose Sprachhilfsdienste zur Verfügung. Rufen Sie unter 1-952-854-0795 an.
Cambodian	ចំណាំ៖ ប្រសិនបើអ្នកនិយាយ (ភាសាខ្មែរ) សេវាកម្មជំនួយខាងភាសាដោយឥតគិតថ្លៃនឹងមានសម្រាប់អ្នក។ សូម ទូរស័ព្ទទៅកាន់ 1-952-854-0795 ។
Arabic	ملاحظة: إذا كنت تتحدث (العربية)، فيرجى العلم بأنه يمكنك الاستفادة من خدمات المساعدة اللغوية مجانًا. اتصل بالرقم: 1-952-854-0795.
French	Attention : Si vous parlez (Français), des services langagiers vous sont offerts gratuitement. Veuillez composez le 1-952-854-0795.

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

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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 ACTIVE 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. Nondiscrimination under Section 1557 of the Patient Protection and Affordable Care Act – Page 45

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 45.

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. 14 - Page 64

Effective January 1, 2017, the Plan is amended to revise exclusion No. 14 regarding Lifestyle and Cosmetic drugs to provide as follows:

14. Lifestyle and cosmetic drugs are not covered, except drugs prescribed specifically for the treatment of acne, sex transformation, or erectile dysfunction. Erectile dysfunction drug coverage is limited to fifteen (15) unit doses per month per Participant.

3. Exclusion No. 25 – Page 64

Effective January 1, 2017, the Plan is amended to eliminate exclusion No. 25 regarding sex transformation.

25. Intentionally left blank.

4. Statement of Nondiscrimination - New Page Page 88-89

Effective October 16, 2016, the Plan adds the following pages 88-99 regarding non-discrimination to the Plan.

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    - 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.
Hmong	Faj Seeb: Yog hais tias koj hais (Hmoob), kev pab cuam pab txhais lus, dawb tsis tau them, yeej muaj muab rau koj. Hu 1-952854-0795.
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。

Russian	Внимание: Если Вы говорите на (Русском), услуги лингвистической поддержки доступны Вам бесплатно. Звоните 1-952-854-0795.
Laotian	ໝາຍເຫດ: ຖ້າທ່ານເວົ້າພາສາລາວ, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. ໂທຫາ 1-952-854-0795.
Amharic	ማሰሰቢያ: የሚገሩት (አሚኛ) ቋንቋ ከሆነ ከክፍያ ነጻ የሆነ የቋንቋ እገዛ አገልግሎት ማግኘት ይችላሉ። በስልክ ቁጥር 1-952-854-0795 ይደውሉ።
Karen	w>'k;oh.ng=erh>uwdR (unDusdm)< usdmw>rRpXRw>zH;w>rRwz.< vXwvXmbl;vJ< td.vXe*D>M.vDRI ud;vD wJpdql 1-952-854-0795 wuh>I
German	Hinweis: Wenn Sie (Deutsche) sprechen, stehen Ihnen kostenlose Sprachhilfsdienste zur Verfügung. Rufen Sie unter 1-952-854-0795 an.
Cambodian	ចំណាំ៖ ប្រសិនបើអ្នកនិយាយ (ភាសាខ្មែរ) សេវាកម្មជំនួយខាងភាសាដោយឥតគិតថ្លៃនឹងមានសម្រាប់អ្នក។ សូម ទូរស័ព្ទទៅកាន់ 1-952-854-0795 ។
Arabic	ملاحظة: إذا كنت تتحدث (العربية)، فيرجى العلم بأنه يمكنك الاستفادة من خدمات المساعدة اللغوية مجانًا. اتصل بالرقم: 1-952-854-0795.
French	Attention : Si vous parlez (Français), des services langagiers vous sont offerts gratuitement. Veuillez composez le 1-952-854-0795.
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

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.

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 2016

IMPORTANT ANNOUNCEMENT FOR ACTIVE 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. In-Patient Out-of-Network – Page 4

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 addition of the following to the Schedule of Benefits on Page 4:

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 7

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 11

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. Retiree Coverage – Page 34

Effective February 1, 2016, the provisions regarding Eligibility for Retirees – Collectively Bargained Employees, are revised to provide as follows:

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

- Make written application to the Board of Trustees within 31 days following the date of your active coverage under this Plan ends;
- Are eligible to receive a pension from the Sheet Metal Workers Local #10 Pension Fund, the Sheet Metal Local #10 Supplemental Retirement Fund, the Sheet Metal Workers National Pension Fund and/or the Production Sheet Metal Workers' Local 10 Retirement Plan;
- 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; and
- At the time of your application for coverage, and at any time thereafter, are not performing the same or similar work in the same or similar industry in which you worked while active and for which contributions were required to the Fund pursuant to a collective bargaining agreement.

5. Other Covered Expenses – Page 47

Effective September 1, 2016, the Plan is amended by deleting No. 1 on page 47 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 66

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 80.

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

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

September 2014

IMPORTANT ANNOUNCEMENT FOR ACTIVE 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. Dollar Bank – Page 22

Effective July 1, 2014, the Plan is amended to provide for an annual increase in the maximum amount a participant may accrue in their Dollar Bank of $1,000 per year starting July 1, 2014 through the year starting July 1, 2018. Per this amendment, a participant will be able to accrue up to the following maximums the next five years. As of July, 1, 2018, the maximum a participant may accrue in the dollar bank is $30,000.

Year	Dollar Bank Maximum
7/1/2014	$26,000
7/1/2015	$27,000
7/1/2016	$28,000
7/1/2017	$29,000
7/1/2018	$30,000

2. Dollar Bank – Page 23

Effective January 1, 2015, the last paragraph of the Dollar Bank section on page 23 of the Summary Plan Description and Plan Document is deleted and replaced with a new last paragraph which will provide as follows:

> Dollar Bank Conversion to Retiree HRA Account: When you retire, coverage for you and your Dependents will end under the active plan at the end of the month with your last day worked unless you use Dollar Bank reserves to continue active coverage for a maximum of three months. Thereafter, your Dollar Bank will be converted to a Retiree HRA Account to be administered under the Retiree HRA Account Plan section of the Sheet Metal #10 Benefit Fund for Retired Participants (Retiree Plan). Under the Retiree Plan you can use your Retiree HRA Account to pay for coverage under the Sheet Metal #10 Benefit Fund's Retiree Plan. You may be eligible for retiree coverage if you meet the Retiree Plan's eligibility requirements or you can elect COBRA Continuation Coverage.

3. Skilled Nursing Care – Page 4

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

4. 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.

5. Prescription Drug Benefit – Page 53

Effective November 1, 2014, the following provisions are added to the end of the Prescription Drug Benefit Section on page 53:

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.

6. Erectile Dysfunction Drugs – Page 64

Effective June 1, 2014, exclusion No. 14 on page 64 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.

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

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 2014

IMPORTANT ANNOUNCEMENT FOR ACTIVE PARTICIPANTS

Summary of Material Modifications

The Trustees of the Sheet Metal #10 Benefit Fund announce the following changes to the Plan for Active 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 60 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. Vision Benefits

Effective January 1, 2014 the Plan's Vision Benefit is amended to increase the benefit to $350 over a two year calendar year period. The first two-year period is 2014-15 and the second two-year calendar year period is 2016-17. Previously this benefit was $175 annually.

Additionally, for Dependents under age 19, there will be the following vision benefits:

- 100% coverage on the first $350 of Vision Benefits and 50% thereafter.
- Coverage for one set of contact lenses or one pair of eyeglasses every two years, subject to the above noted coinsurance requirements.
- One routine eye examination per year is provided without any co-insurance.

Additionally, effective February 1, 2014, the Plan's vision benefit discount network will change from EyeMed to Vision Service Plan (VSP) Vision Care. VSP Vision Care is the largest network in the nation of private practice doctors. For information regarding VSP Vision Care you can visit their website at www.vsp.com.

As a result of the above noted changes, the new Schedule of Benefits of Vision Benefits will provide as follows:

Vision Benefit (See page 58)	Coverage – Plan A	Coverage - Plan B
Two Year Maximum for individuals 19 and older (the two year periods are 2014-2015 and then 2016 -2017):	$350 (in 2014-15 and another $350 in 2016-17).	$350 (in 2014-15 and another $350 in 2016-17).
For Individuals under age 19:	100% coverage on the first $350. Thereafter the plan pays 50%. The Plan provides one set of contact lenses or one pair of eyeglasses every two years subject to the above noted coinsurance requirements. The above noted coinsurance requirements do not apply to one routine eye exam per year.	100% coverage on the first $350. Thereafter the plan pays 50%. The Plan provides one set of contact lenses or one pair of eyeglasses every two years subject to the above noted coinsurance requirements. The above noted coinsurance requirements do not apply to one routine eye exam per year.
LASIK Eye Surgery	$500	$500

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. Dental Benefits (For Dependents under age 19 only)

Effective January 1, 2014, the $2,500 dollar maximum every two years applicable under Dental Benefits Coverage A, B and C and will not apply to Dependents under age 19. Additionally, the lifetime maximum for Coverage D for non-cosmetic orthodontic services will not apply for Dependents under age 19.

The Schedule of Benefits will provide as follows:

Dental Benefit (see page 54)	Coverage – Plan A	Coverage – Plan B
Maximum every two Calendar Years This maximum will not apply to an individual under age 19 for Dental Benefits under Coverage A, B and C.	$2,500	$2,500
Lifetime Maximum for D services (unless medically necessary). This maximum will not apply to an individual under age 19 for non-cosmetic orthodontic services.	$2,500	$2,500

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

6. Health Education – Page 3

Effective January 1, 2014, the Plan has amended its Health Education Benefit fto 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

7. Definition of Dependent

Effective January 1, 2014 the Plan's definition of Dependent for both Active and Retiree Coverage 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.

Important Note – Retiree Opt-Out Rule

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. You may want to consider this option as you approach the time you wish to retire as an active participant and transition your coverage to the Retiree Plan.

Very Truly Yours

Board of Trustees

Notice Regarding "Grandfathered" Status

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

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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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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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Sheet Metal #10 Benefit Fund

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August 2013

IMPORTANT ANNOUNCEMENT FOR ACTIVE 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) 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 Coverage A and Coverage B in the Schedule of Benefits for both individuals and families as further indicated below:

Eligible Employees and Dependents Major Medical Expense Benefit	Coverage – Plan A	Coverage – Plan B
Annual Deductible Before the Plan pays for most covered expenses, you pay	$125 per person each year; $375 family maximum	$545 per person each year; $1,635 family maximum

Previously, the deductible for Coverage A was $115/individual and $345/family and for Coverage B was $500/individual and $1,500/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 Coverage A and Coverage B in the Schedule of Benefits, for both individuals and families as further indicated below:

Eligible Employees and Dependents Major Medical Expense Benefit	Coverage – Plan A	Coverage – Plan B
Annual Out-Of-Pocket Maximum Plan Pays 100% of Covered Charges for the remainder of the year, once you reach your Out-Of-Pocket Maximum: Individual Out-Of-Pocket Maximum Family Out-Of-Pocket Maximum Annual Out-Of-Pocket Maximum does not include your deductible	 $980 per person $2,940 family maximum	 $1,635 per person $4,905 family maximum

Previously, the out-of-pocket maximums for Coverage A were $900/individual and $2,700/family and for Coverage B were $1,500/individual and $4,500/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 Plan Coinsurance	 $100 per person 80% of Reasonable and Customary

Very Truly Yours,

Board of Trustees

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Notice Regarding "Grandfathered" Status

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