SHEET METAL #10 BENEFIT FUND

SUMMARY PLAN DESCRIPTION/PLAN DOCUMENT

FOR RETIRED PARTICIPANTS

June 1, 2010

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

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June 1, 2010

To All Retired Eligible Participants:

We are pleased to provide you with this revised and updated 2010 Summary Plan Description For Retired Eligible Participants (Retiree SPD). We are proud of the benefits package that we are able to provide to you and your family. Please read this Retiree SPD carefully and share it with your family, because there have been many changes. This SPD describes the eligibility requirements for coverage and the benefits provided through the Sheet Metal #10 Benefit Fund as of June 1, 2010. We have changed the format of this SPD in an effort to make it easier to use.

Please note there are two (2) Schedules of Benefits: one for Retirees who retired on or after November 1, 1977 (p. 2) and one for Retirees who retired before November 1, 1977 (Appendix). Please make sure you determine which Schedule of Benefits applies to you.

Included as part of this SPD are these sections:

- *Important Contact Information* (Page 10), which provides contact information for the various benefits provided by your plan;
- *Schedule of Benefits* (Page 2), which is a Summary of the Benefits available to you under the Plan; (Schedule of Benefits for those who retired before November 1, 1977 is listed on the Appendix at the end of this document);
- *Eligibility* (Page 20), which describes when you become eligible for benefits and when you lose eligibility; and
- *Life Events* (Page 29), which explains what happens to your benefits and what you may need to do when certain life events happen.

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

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

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

Sincerely yours,
Board of Trustees

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

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INTRODUCTION

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

About This Booklet

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

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

Your Responsibility

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

This booklet has been prepared for eligible retirees in the Sheet Metal #10 Benefit Fund and describes the benefits in effect as of June 1, 2010. This edition replaces and supersedes any previous summary plan description. The Trustees reserve the right and have the authority to amend, modify, eliminate benefits, or terminate the Plan at any time. In addition, the Trustees, or such other persons as delegated by the Trustees, have the discretion to interpret and construe the rules of the Plan and the terms of this booklet.

Schedule of Benefits If You Retired On or After November 1, 1977

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

Eligible Retirees And Dependents **Major Medical Expense Benefit**	**Coverage**
Lifetime Maximum:	$500,000 NOTE: Your Lifetime Maximum under the Active Plan re-sets to $0 upon commencement of your participation under the Retiree Plan, regardless of the amount incurred while covered as an Active Employee. If you return to the status as an Active Employee, then you will return to the level you had before you became a participant as a retiree. If you subsequently return as a participant under the Retiree Plan, then you will return to the amount you had prior to returning as an Active Employee.
Once you reach the Lifetime Maximum, the Plan only provides reimbursement for Catastrophic Insurance up to $15,000 per year. If you are Medicare-Eligible, then this does not apply.	
Annual Deductible: Before the Plan pays for most covered expenses, you pay	$100 per person each year; $300 family maximum
Coinsurance:	80%, up to the annual out-of-pocket maximum
Annual Out-Of-Pocket Maximum: Plan Pays 100% Of Covered Charges For The Remainder Of The Year, Once You Reach Your Out-Of-Pocket Maximum: Individual Out-Of-Pocket Maximum Family Out-Of-Pocket Maximum Annual Out-Of-Pocket Maximum Does Not Include Your Deductible	**Does not Apply to Mental Health and Substance Abuse Treatment and Pharmacy** $800 per person $2,400

Office Visits And Testing At Retail In-Network Walk-in Clinics:	100% of Reasonable and Customary, no deductible. Urgent Care and Emergency Care are not included in this benefit.
Immunizations: Plan Pays	 100% of Reasonable and Customary after deductible
Physical Exam (including Cancer Exam):	 Once every year.
Elective Sterilization: Lifetime Maximum Plan Coinsurance	 $800 per person 80% of Reasonable and Customary
Orthotics: Calendar Year Maximum Plan Coinsurance	 $100 per person 80% of Reasonable and Customary
Wigs For Hair Loss Due To Chemotherapy Or Illness:	One wig up to $500 (lifetime maximum)
Chiropractic Treatment: Office Visit Maximum Annual Maximum Annual Maximum For Diagnostic X-Rays	 80% after annual deductible up to a maximum of $30 per visit. $750 per person $150 per person
Speech & Occupational Therapy: Lifetime Maximum	 $7,500 per person
Mental Health And Substance Abuse Treatment: *Outpatient* Once You Meet Your Annual Deductible, The Plan Pays *Inpatient* (Including Partial Hospitalization And Day Care) Once You Meet Your Annual Deductible, The Plan Pays Lifetime Maximum For Inpatient Substance Abuse Treatment	*No Out of Pocket Maximum* 80%, up to 10 visits annually* 80%, up to a 14 day maximum per stay* 56 days
Health Education: Plan Coinsurance Calendar Year Maximum Lifetime Maximum	 80% of Reasonable and Customary $600 per person $6,000 per person

* May be extended with approval from T.E.A.M., Inc.

Skilled Nursing Care:	
Daily Room And Board	100% of Reasonable and Customary
Confinement Maximum	30 days; must have at least 60 days in between confinements
Emergency Room:	$50.00 Co-payment. If admitted to the hospital, then the $50.00 co-payment is waived.
Hospice Care:	
Lifetime Maximum	185 days per person
Counseling Lifetime Maximum	$500
Bereavement Counseling Lifetime Maximum	$250
Home Health Care:	
Maximum Days Per Calendar Year	120 days
Hearing Care:	
Plan Coinsurance	80% of Reasonable and Customary
Maximum Benefit For:	
One Examination Per Two Consecutive Calendar Years	$150
Two Hearing Aid Instruments Per Five Consecutive Calendar Years	$1,000 (per ear)
Temporomandibular Joint Disorder (TMJ or TMD):	
Lifetime Maximum For Appliances	$600 (Your Lifetime Maximum under the Active Plan re-sets to $0.)

Pharmacy Benefit:	
Prescription Drugs – Will Not Be Subject to an Annual Deductible or Out-of-Pocket Maximum. Retail Pharmacy	Brand Drugs: Participant Pays 20% of the Cost at the In-Network Pharmacy and the Plan Pays the Remaining 80%.. Generic Drugs: Participant pays 10% of the cost at the In-Network Pharmacy, and the Plan pays the remaining 90%.
If Another Drug Plan Is Primary Or Paid By The Veterans Administration	100% of copayment requires no deductible.
Mail Service If Plan Coverage Is Primary For You	80% Generic Drugs: Participant pays 10% of the cost at the In-Network Pharmacy, and the Plan pays the remaining 90%.
Specialty Drug Program Specialty drugs are typically medications that require close supervision and monitoring of the patient's therapy; need frequent dosage adjustments; need special storage, handling, and administration; and are significantly more costly than traditional drugs.	
If you use the Specialty Drug Program	Plan pays 100%
If you do not use the Specialty Drug Program	Not covered
Dental: For Participants Who Elect This Benefit and Pay the Required Premium	Benefits Payable Under Optional Separate Dental Policy.
Vision:	Card provides discount at some Retail outlets. But there is no other Benefit including reimbursement.

Important Contact Information

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

If you have a question or need information about	Contact	Phone numbers	Web site
Eligibility, ID Cards, And Medical claims and benefits questions	Wilson-McShane Corporation 3001 Metro Drive, #500 Bloomington, MN 55425	(800) 535-6373 (952) 854-0795	N/A
Dental Benefits	Delta Dental	(651) 406-5900	www.deltadentalmn.org
To find a Preferred Provider: Medical &	Blue Cross Blue Shield	Use web site	www.bluecrossmn.com
Prescription Drug	Prime Therapeutics	(800) 858-0723	www.primetherapeutics.com
Employee Assistance Plan	T.E.A.M., Inc.	(800) 634-7710 or (651) 642-0182	
General Assistance and Information	Sheet Metal Benefit Fund Office	(651) 770-0991 (800) 396-2903	www.smw10.org

Important Notices

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

- When the term "you" is used, it means you and/or your eligible Dependents.
- The Board of Trustees reserves the right to interpret, amend, or terminate any and all provisions of the Plan.
- It is important that you notify the Fund Office whenever you:
  - Change your home/mailing address;
  - Enter and return from the uniformed services of the United States;
  - Divorce;
  - Have a Dependent who no longer meets the Plan's definition of a Dependent to ensure that he or she receives proper COBRA notice.
  - Full-time student documentation must be submitted to Wilson-McShane Corporation each semester. Dependent child coverage requires your election and payment of Dependent child premiums.
- The current Preferred Provider Organizations (PPO's) the Plan uses are:
  - Blue Cross Blue Shield - medical
  - Prime Therapeutics - prescription drugs
  - T.E.A.M., Inc. - employee assistance plan
- The Plan reserves the right to change or discontinue any PPO anytime.
- The Plan may receive rebates from Prime Therapeutics for prescriptions purchased under the Plan. These rebates will be used to reduce the Plan's expenses.

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

Definitions

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

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

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

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

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

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

Catastrophic Insurance: the specific coverage limit paid for all charges combined and actually paid by the Plan under that coverage. The Plan's payment ceases when that limit is reached, at which point you must pay for subsequent charges. However, the Plan will reimburse you for the insurance premiums to cover subsequent charges up to the annual maximum.

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

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

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

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

Covered Dependent: Includes any of the following persons who are eligible for coverage under this Plan as a Covered Dependent, provided they are not also an eligible Covered Employee:

(1) Your spouse or surviving spouse from who you are not divorced or legally separated; or

(2) Each unmarried child who has not yet reached age 19 (or age 25, if the child is a full-time student), is dependent on the Employee for more than one-half of the child's support during the calendar year and maintains a principal place of residence with the Employee during the calendar year, including: For all Dependent definitions, the child must be born prior to the Participant's election for Retiree coverage. Any child born after retirement will not be considered a dependent child.

(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) Any of the following who live with the Employee in a regular parent-child relationship:

(i) A stepchild only for the duration of the marriage of the Eligible Employee and the stepchild's parent,

(ii) Each unmarried child over age 19 attending an accredited school or college as a full-time student until the child reaches age 25. Students who are living away at school are considered to maintain a residence with the Employee if they use the Employee's residence as their permanent residence for mail purposes and reside with the Employee during non-school time. Official documentation of full time attendance from the accredited school must be submitted every quarter or semester to verify that a Dependent is a full-time student.

Coverage of all dependents age 24 during a Plan Year could be taxable to the Eligible Employee. The Fund Office will provide you with an applicable tax form and we urge you to consult with your tax advisor regarding the taxability of this benefit.

(iii) An unmarried child who is named as an alternate recipient 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 Fund. The Plan has adopted procedures for Qualified Medical Child Support Orders. These procedures are available upon request from the Fund Office.

Extension of Benefits for Dependent Children for Serious Medical Conditions

A Dependent child who is eligible for coverage based on qualifying student status at a postsecondary educational institution whose serious illness or injury requires a leave of absence or change in enrollment that would cause the Dependent Child to lose coverage will be granted a one-year extension of benefits.

To request this extension of benefits, the Participant must submit written certification from the Dependent Child's physician certifying that the child is experiencing a serious illness or injury, and that the leave of absence or other change in enrollment from the postsecondary institution is medically necessary.

Note that the one-year extension of benefits will apply only if the Participant maintains coverage, either through continuing eligibility, self-payment or COBRA continuation coverage. The extension of benefits will end if the Participant's coverage terminates.

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

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

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

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

Fund Administrator: the Fund's Board of Trustees.

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

Home Health Care Agency: any of the institutions listed below.

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

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

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

Hospice Agency: a public or private organization that:

1. Administers and provides hospice care; and
2. Is either:

A. Licensed or certified as such by the state in which it is located;

B. Certified (or is qualified and could be certified) to participate as such under Medicare;

C. Accredited as such by the joint commission on the accreditation of Hospitals; or

D. Able to meet the standard established by the national hospice organization.

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

1. By providing palliative (pain controlling) and supporting medical, nursing and other health services; and

2. Be provided through home or inpatient care during the sickness or bereavement.

Hospice Services: any services provided:

1. Under a hospice plan; or

3. By a Hospital or related institution, home health agency, hospice or other facility licensed by the state to operate a hospice.

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

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

1. Accommodations for resident patients;

2. Facilities for the treatment of mental or nervous disorders;

3. A resident psychiatrist always on duty or call; and

4. As a regular practice, charges the patient for the expense of confinement.

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

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

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

Medicare: the two health care programs, Part A - a Hospital benefit plan and Part B - a supplementary medical benefits plan, which are established by Title XVIII of the Social Security Act of 1965, as

amended. Medicare also includes Part D – prescription drug coverage, established by the Medicare Modernization Act of 2003.

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

Mental or Nervous Disorder: all forms of illnesses in which psychological, intellectual, emotional, or behavioral disturbances are the dominating features as manifested in maladaptive behavior or impaired functioning, whether caused by genetic, physical, chemical, biological, environmental, psychological, social, or cultural factors; that also meet the criteria further described in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders and any subsequent revisions thereto, of the American Psychiatric Association.

Mental illness includes:

- Schizophrenia;
- Schizoaffective disorder
- Bipolar disorder (manic-depressive illness);
- Major depressive disorders;
- Panic disorders;
- Obsessive-compulsive disorder;
- Pervasive development disorder or autism;
- Anorexia nervosa; and
- Bulimia nervosa.

Serious emotional disbursement of a child is defined as a child who:

1. Has one or more mental disorders identified in the DSM, other than primary substance abuse disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms, and
2. As a result of the mental disorder, one of the following occurs:
   A. The child has substantial impairment in at least two of the following areas: self care, school functioning, family relationships, or ability to function in the community; and either of the following occurs:

      I. The child is at risk of removal from home or has already been removed from the home,

      II. The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment, or

      III. The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder; or

      IV. The child meets special education eligibility requirements (in an "individual with exception needs" identified by an individual education program team as a child with a disability), and the child's impairment requires instruction, services, or both, which cannot be provided with modification of the regular school program.

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

Obstetrical Procedure: any of the procedures listed below:

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

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

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

Pre-Existing Condition: any injury, illness, sickness or medical condition that has manifested itself when medical care, treatment or diagnosis have been given by a health care provider within the last six (6) months to you or your covered Dependent. For any injury, illness, sickness, or medical condition that is deemed excludable as a pre-existing condition, the Plan will exclude coverage up to twelve (12) months.

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

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

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

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

Qualified Medical Child Support Order (QMCSO): a judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction requiring that a medical child support order recognize an eligible Retiree's child as an alternate recipient. This order must be approved by the Board of Trustees and the child must meet the definition of a Dependent.

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

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

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

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

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

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

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

1. Is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require Medically Necessary care, or rehabilitation services for the rehabilitation of injured, disabled or sick persons;
2. Has policies, which are developed and periodically reviewed by a group of professional personnel, including one or more Physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services provided;
3. Has a Physician, a registered professional nurse or a medical staff responsible for the execution of such policies;
4. Has a requirement that the health care of every patient be under the supervision of a Physician and provides for having a Physician available to furnish necessary medical care in case of emergency;
5. Maintains clinical records on all patients;
6. Provides 24-hour nursing services that is sufficient to meet nursing needs in accordance with the policies developed and has at least one registered professional nurse employed full time;

7. Provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;
8. In the case of an institution in any state in which state or applicable local law provides for the licensing of institutions of this nature is:
   A. Licensed pursuant to such law; or
   B. Approved by the agency of the state or locality responsible for licensing institutions of this nature as meeting the standards established for such licensing; and
9. Meets any other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to their physical facilities.

Specialty Drug: A medication that typically requires:

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

Surgical Procedure: any procedure in the categories listed below:

1. The incision, excision or electro cauterization of any organ or part of the body;
2. The manipulative reduction of a fracture or dislocation;
3. The suturing of a wound;
4. The removal by endoscopic means of a stone or other foreign object from the larynx, bronchus, trachea, esophagus, stomach, urinary bladder or ureter; or
5. Laser surgery and lithotripsy.

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

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

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

ELIGIBILITY RULES FOR RETIREES WHO RETIRED ON OR AFTER NOVEMBER 1, 1977

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.

When you retire, you may be able to:

- ***Elect retiree coverage; or***
- ***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 Fargo Pension Fund, the Sheet Metal Local #10 Supplemental Retirement Fund and/or the Sheet Metal Workers National Pension Fund; 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.

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

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

Disabled Employee Eligibility

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

1. retired before you reached age 55 on a Pension from either the Local 10 Pension and/or the National Pension Plan;

2. retired because of a disability that prevented you from performing the duties required of a sheet metal worker;

3. had at least 11,500 hours of employer contributions made on your behalf immediately preceding your disability;

4. did not qualify for benefits from Medicare (*If you qualify for Medicare benefits from Social Security, then you are eligible for normal Retiree Coverage.*); and

5. apply for and made the required contributions to the Fund for this coverage.

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

Effective Date of Retiree Benefits

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

Self-contributions

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

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

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

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

Qualified Medical Child Support Orders (QMCSO'S)

If a copy of a Medical Child Support Order as defined in ERISA Section 609(a), or other order designating medical child support, is filed with the Fund Office, the Fund Administrator shall promptly notify the Retiree and each alternate recipient of the receipt of such order and the Plan's procedure for determining whether the order is a Qualified Medical Child Support Order [QMCSO], as further defined in ERISA Section 609(a). The Fund Administrator shall determine whether the order is a QMCSO pursuant to the Plan's procedures, and notify the Retiree and each alternate recipient of the determination. The Plan shall provide benefits for anyone who is eligible as a Dependent under the Plan. The terms of the QMCSO are not in conflict with the terms of this Plan. Any payment for benefits made by the Plan pursuant to a QMCSO in reimbursement for expenses paid by an alternate recipient's custodial parent or legal guardian shall be made to the alternate recipient's custodial parent or legal guardian. There must be an election and payment for dependent coverage.

Termination of Eligibility

Your coverage will stop on the earliest of:

1. the day that your pension from the Sheet Metal Workers Local #10 Pension Fund, the Fargo Pension Fund, or from the Sheet Metal Workers' National Pension Plan ceases or is suspended – unless any one of these Funds allows for such work to occur. You will remain eligible under this Retiree Plan until you become eligible under the Active Plan;

2. the last day of the month for which self-contributions were last made;

3. the day you re-establish your eligibility for Active Employee benefits in accordance with the Eligibility Rules;

4. the day you return to work in the Sheet Metal Trade in the jurisdiction of the Sheet Metal #10 Benefit Fund if contributions are not being remitted to the Benefit Fund for such work or;

5. the date the Plan ends.

Termination of Eligibility for Dependents

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

1. the date your eligibility under the Plan terminates;

2. the date your Dependent no longer meets the definition of Dependent;

3. the date your Dependent becomes eligible for coverage under the Active Plan;

4. the date your Dependent enters the Uniformed Services of the United States; or

5. the date the Plan ends.

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

Keep Your Plan Informed of Address Changes

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

Retirees Who Return From Service With the International Union

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

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

1. the normal retirement benefits at the normal retirement rates, or

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

Retiree Benefits – Non-Bargained Employees

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

Supplemental Medicare Wraparound Plus Plan (SMW+)

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

Re-retirement

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

The lifetime maximum retiree benefits to which you will be entitled will be equal to $500,000 less any retiree benefits received prior to reestablishment of eligibility as an Active Employee.

Special Dependent Continuation Coverage

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

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

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

COBRA Continuation Coverage

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

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

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

Who is Entitled to COBRA Continuation Coverage

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

A qualified beneficiary is a Dependent of an eligible Retiree who was covered by the Plan when a qualifying event occurred. A child who becomes a Dependent child by birth, adoption, or placement for adoption with your during a period of COBRA Contribution Coverage is also a qualified beneficiary. A

person who becomes your spouse during a period of COBRA Continuation Coverage is not a qualified beneficiary. You must notify the Fund Office within 31 days after the date of marriage, birth, adoption or placement for adoption, or loss of full-time student status.

COBRA Qualifying Events

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

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

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

In the event of a Retiree's death, the Retiree's spouse has an option of electing either Special Dependent Continuation Coverage or COBRA.

Please note that if your Dependents do not elect COBRA their future healthcare coverage could be affected as follows:

- If they have more than a 63-day gap in health coverage, then they may have pre-existing condition exclusions applied to them by other group health plans. Electing COBRA may help them avoid a gap in coverage.
- If they do not elect COBRA Continuation Coverage for the maximum time available to them, then they may also lose the guaranteed right to purchase individual health insurance policies that do not impose pre-existing condition exclusions.

Special Enrollment Rights

If your Dependents' coverage ends because of a qualifying event, your Dependents have special enrollment rights for 30 days after coverage loss to enroll under another group health plan, in which they are eligible; i.e. a plan sponsored by your spouse's employer.

Maximum Period Of COBRA Continuation Coverage

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

When The Plan Must Be Notified Of A Qualifying Event

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

Notices Related To COBRA Continuation Coverage

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

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

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

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

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

Paying For COBRA Continuation Coverage

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

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

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

COBRA Cancellation For Non-Payment

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

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

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

Disability Extension Of COBRA Continuation Coverage 18-Month Period Only

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

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

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

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

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

Early Termination Of COBRA Continuation Coverage

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

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

Notice Of Early Termination Of COBRA Continuation Coverage

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

Certification Of Coverage When Coverage Ends

When your Dependents' coverage ends, the Fund Office will provide your covered ***Dependents*** with a certificate of creditable coverage that indicates the period of time they were covered under the plan. If, within 62 days after your Dependents' coverage under this plan ends, your covered ***Dependents*** become eligible for coverage under another group health plan, or if your covered ***Dependents*** purchase a health insurance policy, your Dependents may need this certificate to reduce any exclusion for pre-existing conditions that may apply to your covered ***Dependents*** in that group health plan or health insurance policy. The certificate will indicate the period of time they were covered under this plan, and certain additional information that is required by law.

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

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

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

Life Events

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

Getting Married

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

Adding A Child

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

Getting Legally Separated Or Divorced

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

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

What You Need To Do

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

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

Child Losing Eligibility

Your child is no longer eligible for coverage when he or she marries, enters the military on a full-time basis, reaches the limiting age, or is no longer Dependent upon you for support or otherwise fails to meet the Plan's eligibility rules. (see pages 12-13 for a definition of Covered Dependent). If your child loses eligibility, your child may elect to continue coverage under COBRA (see above).

Taking A Military Leave

If you enter into military service (active duty or inactive duty training) for up to 31 days, your health coverage will continue as long as you make the required self-payment. If you are called into military service for more than 31 days, you may continue your coverage by paying the required self-payments for up to 24 months or, if sooner, the end of the period during which you are eligible to apply for reemployment in accordance with the uniformed services employment and reemployment rights act of 1994 (USERRA).

Your coverage will continue to the earliest of the following:

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

If You Do Not Continue Coverage Under USERRA

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

What You Must Do

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

What if I die?

Your Covered Dependents will be eligible for Continuation Coverage as stated on pp. 24-28 of this SPD.

MAJOR MEDICAL EXPENSE BENEFIT

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

How The Plan Works

Annual Deductible

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

Co-Payment

After you pay the annual deductible, you and the Plan share in the cost of covered medical expenses. The Plan's co-payment is a specified percentage of covered medical expenses, and your co-payment is the balance of the percentage up to 100%, until you have reached your out-of-pocket maximum. Please refer to the Schedule of Benefits for the specific percentages. After you have reached your out of pocket maximum, the Plan pays 100% of covered medical expenses for the remainder of the calendar year. The out-of-pocket maximum does not apply to mental health, substance abuse, and prescription related expenses.

Annual Out-Of-Pocket Maximum

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

Lifetime Maximum / Catastrophic Insurance

This provision applies to when a covered individual reaches the maximum amount of coverage under the Fund's Major Medical Benefits and Prescription Drug provisions in the Schedule of Benefits. All Major Medical Benefits and Prescription Drug coverage will terminate for that covered individual on the date his/her lifetime maximum is met for paid claims for covered Major Medical expenses, as outlined in the Schedule of Benefits. Each participant and individual dependent accumulates their own separate Lifetime Maximum.

Once a covered individual reaches their Lifetime Maximum under the Plan, as shown in the Schedule of Benefits, the Plan will continue to pay benefits up to the catastrophic insurance maximum each year. The Plan's Catastrophic Insurance maximum stated on the Schedule of Benefits may be used for reimbursement of the cost of substitute insurance premiums and co-insurance, co-pays and deductibles applicable to such substitute insurance.

Additionally, if you exceed the Lifetime Maximum for Major Medical Benefit coverage, you will remain eligible for the following Plan benefits:

1. Vision
2. Dental; and
3. Hearing Care

Extended Coverage for Students with Serious Illness:

A Dependent child who is eligible for coverage based on qualifying student status at a postsecondary educational institution whose serious illness or injury requires a leave of absence or change in enrollment that would cause the Dependent Child to lose coverage will be granted a one-year extension of benefits.

To request this extension of benefits, the Participant must submit written certification from the Dependent Child's physician certifying that the child is experiencing a serious illness or injury, and that the leave of absence or other change in enrollment from the postsecondary institution is medically necessary.

Note that the one-year extension of benefits will apply only if the Participant maintains coverage, either through continuing eligibility, self-payment or COBRA continuation coverage. The extension of benefits will end if the Participant's coverage terminates.

Benefit Substitution

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

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

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

Covered Major Medical Expenses

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

Women's Health And Cancer Rights Act Of 1998

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

Substance Abuse And Mental Or Nervous Treatment

Treatment is covered up to the limits shown in the Schedule of Benefits. If additional visits or inpatient days are Medically Necessary, you or your provider must contact T.E.A.M., Inc. and, get approval for additional treatment.

Coverage

Your co-payment amount for substance abuse and mental/nervous treatment will not be applied toward your out-of-pocket maximum. Your co-payment remains the same amount regardless of the amount of covered medical expenses incurred. Covered expenses for treatment for substance abuse are subject to lifetime major medical limits (see the *Schedule of Benefits*). **Completion of the treatment program is required before the Plan pays for the Treatment benefits.**

Home Health Care Benefit

Covered expenses for home health care services and supplies furnished in the patient's home by a Home Health Care Agency and according to a Home Health Care Plan will be paid up to the maximum shown in the *Schedule of Benefits* (see page 4).Covered expenses are:

- Part-time or intermittent nursing care provided by a registered nurse or a licensed practical nurse supervised by a registered nurse;
- Part-time or intermittent home health aide services that consist primarily of medical care or therapy for the patient;
- Physical, occupational or speech therapy; or
- Prescription drugs, medical supplies, and related pharmacy and laboratory services, which are prescribed by a Physician and would be covered under the Plan if the patient is confined to a Hospital.

The Home Health Care Plan must be:

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

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

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

PRESCRIPTION DRUG CARD PROGRAM

You are able to obtain your prescriptions by paying only your applicable copayment amount at participating Prime Therapeutics network retail pharmacies and the mail service pharmacy. Your prescription drugs are not covered under the Major Medical Expense Benefits and are not subject to the Plan deductible or annual out-of-pocket maximum provisions.

You are required to show your Sheet Metal #10 Benefit Fund identification (ID) card to the pharmacist each time you purchase prescriptions. The amount of copayment that you will be required to pay at the point of service when you use a network pharmacy is as follows:

Brand Name Drugs	- 20% of the cost of the prescription drug
Generic Drugs	- 10% of the cost of the prescription drug

Please keep the following things in mind when purchasing your prescription drugs:

In order to obtain your prescription at a network pharmacy you must show your ID card and you will pay only, the new (reduced) copays listed above.

If you go to an out of network pharmacy, you must pay the full retail cost for the prescription, whether you show your ID card or not, rather than the discounted price that has been negotiated with Prime Therapeutics. You must then submit your receipt to the Fund Administrator for reimbursement. The Prime Therapeutics' network is extensive so there are VERY FEW locations where a network pharmacy is not available. Remember, taking advantage of this discount saves money for both you and the Fund.

The Plan's Mail Order Pharmacy benefit is still available. For many drugs, especially maintenance drugs that you take daily, the Mail Program may provide the most savings to you and the Fund. Please refer to Important Contact Information on page 8.

SPECIALTY DRUG PROGRAM

Prescription medications dispensed as part of the Prime Therapeutics specialty drug program will be covered at 100% with no participant co-payment at the pharmacy.

This does NOT apply to all prescription medications. Specialty drugs are typically medications that generally require close supervision and monitoring of the patient's therapy. These drugs also need:

- Frequent dosage adjustments, and
- Special storage, handling or administration.

Specialty Drugs are also significantly more costly than traditional drugs with a 30-day supply, often costing more than $1,000.00. Some examples of diseases for these medications are:

- Multiple sclerosis treatments
- Hepatitis C
- Certain Cancers
- Drugs used to treat the nausea associated with the chemotherapy and illnesses
- Rheumatoid arthritis and Psoriasis treatments
- Growth hormones
- Medications to treat rare conditions; i.e. Cystic Fibrosis, Gaucher's disease and Hemophilia

There is no reimbursement for specialty drugs obtained outside of the Prime Therapeutics Specialty Drug Network, unless your medication is provided directly by your Hospital or clinic during the course of your treatment.

OTHER PHARMACY

Over the counter ("OTC") Prilosec, a proton pump inhibitor, and OTC Loratadine, a non-sedating antihistamine, are covered at 90% - your copayment is 10%.

In order for the medications 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 an OTC drug, or
2) Get a prescription from your doctor for the OTC drug.

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

Erectile Dysfunction drug coverage is limited to fifteen (15) per month per participant.

Smoking Cessation Drugs. The Plan will provide prescription smoking cessation drugs when prescribed by a physician only if you are actively participating in the Blue Cross/Blue Shield Enhanced Stop Smoking Program and under the guidance of a Quit Coach See p. 41 regarding the Fund's Smoking Cessation benefit. Other quit aids, such as Nicotine Replacement Therapy products are not covered under this benefit and are only available through coverage provided in connection with the Blue Cross/Blue Shield Enhanced Stop Smoking Plan.

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

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

Other Covered Expenses

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

1. Hospital room and board charges up to the standard daily rate for most common type of room.
2. Hospital services and supplies, other than room and board.
3. Physician charges.
4. Services of a registered graduate nurse (R.N.), Registered Nurse Practitioner, Licensed Practical Nurse (L.P.N.), and legally Licensed Physiotherapist. These services must not be provided by a member of your, or your spouse's, immediate family.
5. Diagnostic laboratory and X-ray examinations.
6. X-ray, radium and radioactive isotope therapy.
7. Anesthetics, blood, blood plasma and oxygen.
8. Rental of Durable Medical Equipment. The Plan may decide to purchase equipment if it determines purchase is more economical than rental. A purchase may be made even if rental payments have already been made. The Plan will provide a benefit for the replacement of Durable Medical Equipment only when the replacement is needed due to a change in the member's physical condition or when the original equipment is inoperative and cannot be repaired at a cost less than rental or replacement. The Plan will pay for repair of inoperative equipment if less than the cost of rental or replacement. The Plan will pay the reasonable cost of rental during repair.
9. Artificial limbs, eyes and other non-dental prosthetic devices.
10. Emergency transportation by a professional ambulance service to the nearest Hospital equipped to furnish required treatment. Emergency transportation is also covered for transportation between Hospitals when such transfer results in more highly specialized care. The Fund may require a Physician's statement certifying that the transportation was due to an emergency and that the receiving Hospital was the nearest Hospital equipped to furnish the required treatment.

11. Dental work or oral surgery for the prompt repair of natural teeth when required because of a Non-Occupational Injury. Expenses must be incurred within six months of the injury.

12. Excision of partially or completely interrupted impacted teeth, the excision of a tooth root without the extraction of the entire tooth, or any other incision or excision procedures on the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

13. Cosmetic Surgery for treatment of injuries sustained in an accident and the treatment of birth defects of a Dependent Child.

14. Skilled Nursing Care Facility not to exceed the:

    a. Usual and Customary charge; and

    b. Maximum number of days payable for any one period of confinement, as shown in the Schedule of Benefits (see page 8).

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

15. Orthotics, including examination, X-rays and impressions when prescribed by a Physician up to the amount shown in the Schedule of Benefits.

16. Penile prosthesis provided the implantation is performed in relation to impotence caused by an accidental bodily injury or a non-mental/nervous disease.

17. Well baby immunizations/vaccinations and office visits including sports and school exams.

18. Elective sterilization up to the Lifetime Maximum shown in the Schedule of Benefits.

19. Educational programs for patients or parent(s) of child patients that teach the care and management of chronic diseases (such as diabetes, asthma, etc.) and are designed to improve patient knowledge of the disease and techniques for self-management and compliance with proper health care procedures required for the patient's well-being. Such programs are covered only when ordered by a Physician and if the Participant attended 80% or more of the scheduled classes. The Participant must submit a receipt showing the:

    a. Cost of the program;

    b. Name, address and telephone number of the program sponsor;

    c. Date and times classes were held; and

    d. Classes actually attended by the Participant.

20. Chiropractic services, office visits to a licensed chiropractor, X-rays and diagnostic procedures up to maximum shown in the Schedule of Benefits. Benefits are payable only for visits at the office of a chiropractor.

21. One wig when required to replace hair lost because of chemotherapy or illness up to the maximum shown in the Schedule of Benefits.

22. One physical exam, including cancer exams, per year.

23. Diagnosis, corrective orthopedic appliances, or surgical treatment of Temporomandibular Joint Dysfunction (TMJ). The Lifetime Maximum shown in the Schedule of Benefits applies only for the appliances.

24. Hearing Care, which includes one hearing examination per two consecutive Calendar Years up to the maximum benefit shown in the Schedule of Benefits. Also included is/are hearing aid instrument(s) up to the maximum benefit shown in the Schedule of Benefits. Subject to the Schedule of Benefits, this benefit includes replacement or repair.

    Covered Expenses for Hearing Care do not include:

    a. Medical examinations that are not provided by and hearing aids that are not prescribed by a qualified otologist or otolaryngologist.

    b. Examination by an audiologist when not referred by an otologist or otolaryngologist or when the exam is not followed by an exam by an otologist or otolaryngologist.

    c. Rental or purchase of amplifiers or replacement batteries.

25. Hospice Services for a Participant who has been diagnosed as Terminally Ill up to the Lifetime Maximum number of days, Lifetime Maximum for Counseling and Lifetime Maximum for bereavement Counseling shown in the Schedule of Benefits. Charges must be incurred during a confinement in a hospice or a facility operating under the direction of a Hospice Agency following a Hospice Plan. Covered expenses include:

    a. Counseling of a Participant and the eligible Dependents; and

    b. Bereavement Counseling of the eligible Dependents.

    Counseling and bereavement Counseling must be rendered by a:

    a. Psychiatrist;

    b. Licensed Psychologist; or

    c. Licensed Social Worker.

26. Inpatient hospice benefits are payable when:

    a. There are no suitable Caregivers available to provide hospice benefits;

    b. It is determined by the Hospice Agency that home hospice is impractical because the persons that regularly assist with home care find the patient is unmanageable; and/or

    c. Respite Care is needed.

    Payment will **not** be made for:

    a. Hospice Services and supplies that are not part of a Hospice Plan;

    b. Services of a Caregiver or a person who lives in the Participant's home or is a member of his or her family;

    c. Domestic or housekeeping services that are unrelated to the patient's care;

d. Services that provide a protective environment when no skilled service is required, including companionship or sitter services other than Respite Care;

e. Services that are not directly related to a Participant's medical condition, including (but not limited to);

i Estate planning, drafting of wills or other legal services;

ii Pastoral Counseling or funeral arrangement or services;

iii Nutritional guidance or food services such as "meals on wheels;" or

iv Transportation services.

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

28. Occupational therapy and speech therapy, subject to the Plan's Lifetime Maximum.

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

30. Specialty Drugs as described on p. 35.

31. Bariatric Surgery Benefit as described below.

BARIATRIC SURGERY BENEFIT

You are covered for Bariatric Surgery to the Fund's plan of benefits subject to the following conditions:

- Services for Bariatric Surgery must be obtained from a Blue Distinction Center for Bariatric Surgery*.

- Medically necessary inpatient and outpatient services for Bariatric Surgery are limited to a lifetime coverage maximum of $20,000.

- Prior authorization is required. All prior authorizations should be submitted in writing to:

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

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

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

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

AS TECHNOLOGY CHANGES, THE COVERED BARIATRIC SURGERY PROCEDURES WILL BE SUBJECT TO MODIFICATIONS IN THE FORM OF ADDITIONS OR DELETIONS WHEN APPROPRIATE.

EMPLOYEE ASSISTANCE PROGRAM

The Employee Assistance Program offers confidential counseling for a broad spectrum of personal problems including marital conflicts, legal, financial, family and relationships, alcohol and/or drug dependency, emotional or psychological, spiritual, occupational/vocational and workers' compensation/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 other persons 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 Duluth 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 and Duluth areas, T.E.A.M., Inc. will arrange for a provider in your area to assist you. Please call T.E.A.M., Inc. for further information.

Completion of this program is required in order for the treatment to be covered under the Plan.

ENHANCED SMOKING CESSATION

If you or your eligible dependents smoke and desire to quit, enrollment in the Enhanced Stop Smoking Program will provide you access to a phone-based "Quit Coach" who will guide and support your efforts and supply you with Nicotine Replacement Therapy products such as patches, gum, and lozenges. The Plan will pay the entire cost for these quit aids, if you are enrolled. The Enhanced Stop Smoking Program typically experiences higher participation and a higher quit rate than the basic program.

Any Plan coverage for smoking cessation aids requires the participant to be enrolled in the Enhanced Smoking Cessation program sponsored by BlueCross BlueShield Minnesota. You may enroll by calling 1-888-662-2583.

HEALTHY START PRENATAL SUPPORT

Healthy Start 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 Healthy Start program.
- During the program, you will receive support during and after pregnancy and a comprehensive book "Your Pregnancy & Birth." Upon completion of the program, you will also receive a $50.00 retail store gift certificate.

To enroll, you must call BlueCross BlueShield anytime at (651) 662-1818 or toll free (866) 489-6948. You may also by sending an email to HealthyStart@bluecrossmn.com .

GENERAL EXCLUSIONS AND LIMITATIONS

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

1. Treatment or supplies that are not Medically Necessary.
2. Expenses that are above the covered annual or lifetime limits for the service.
3. Treatment or service not prescribed by a Physician.
4. Injury or sickness arising out of or in the course of any employment for wage or profit.
5. Treatment or service that is compensated for or furnished by the local, state, or federal government or any public agency, and that part of charges for any services or supplies that are provided or available from the local, state, or federal government (for example, Medicare) whether or not that payment is received.
6. Injury, sickness, or death resulting from war or any act of war declared or undeclared.

7. Expenses incurred by you for injuries resulting from or sustained as a result of commission, or attempted commission by you, of an illegal act that the Plan Administrator determines in its sole discretion, on the advice of legal counsel, involves violence or the threat of violence to another person or in which a firearm, explosive or other weapon likely to cause physical harm or death is used by you unless the injury or illness is the result of domestic violence or the commission or attempted commission of an assault or felony is the direct result of an underlying health factor. The Plan Administrator's discretionary determination that this exclusion applies will not be affected by any subsequent official action or determination with respect to prosecution of the Covered Individual (including, without limitation, acquittal, or failure to prosecute) in connection with the acts involved. Voluntary termination of pregnancy (except complications resulting from voluntary termination).
8. Experimental/Investigative services or supplies that do not meet accepted medical practice standards.
9. Medical expenses of a Dependent, other than a spouse, who is entitled to benefits as an Eligible Employee of a Contributing Employer under the Fund's Active Plan of Benefits.
10. Specialty drugs, except those purchased through the Specialty Drug Program unless provided directly by your Hospital or clinic during the course of your treatment. See page 35.
11. Lifestyle and cosmetic drugs, except drugs prescribed specifically for the treatment of acne or for erectile dysfunction.
12. Services or supplies received when the stay is primarily for behavioral problems, social maladjustment, or other antisocial actions, including, but not limited to the following diagnoses:

Conduct Disorders	
312.00	Undersocialized, aggressive
312.10	Undersocialized, non-aggressive
312.23	Socialized, aggressive
312.21	Socialized, non-aggressive
312.90	Atypical
Specific Development Disorders	
315.00	Developmental reading disorder
315.10	Developmental arithmetic disorder
315.31	Developmental language disorder
315.39	Developmental articulation disorder
315.50	Mixed specific developmental disorder
315.90	Atypical specific developmental disorder
Disorders of Impulse Control not Elsewhere Classified	
312.31	Pathological gambling
312.32	Kleptomania
312.33	Pyromania
312.34	Intermittent explosive disorder
312.35	Isolated explosive disorder
312.39	Atypical impulse disorder
V Codes for Conditions not Attributable to a Mental Disorder That are a Focus Not covered of Attention or Treatment	

V65.20	Malingering
V62.89	Borderline intellectual functioning (V62.88)
V71.01	Adult antisocial behavior
V71.02	Childhood or adolescent antisocial behavior
V62.30	Academic problem
V62.20	Occupational problem
V62.82	Uncomplicated bereavement
V15.81	Noncompliance with medical treatment
V62.89	Phase of life program or other life circumstance problem
V61.10	Marital problem
V61.20	Parent-child problem
V61.80	Other specified family circumstances
V62.81	Other interpersonal problem

13. Services or supplies for which the individual is not required to make payment or would have no obligation to pay if he did not have this coverage.
14. Charges for failure to keep a scheduled visit or charges for completion of a claim form.
15. Equipment for personal hygiene, comfort or convenience including, but not limited, to air conditioners, humidifiers, physical fitness and exercise equipment, home traction units, tanning beds, water beds or purifiers, hot tubs, whirlpools, swimming pools, dehumidifiers, orthopedic mattresses, elevators, or stair lifts.
16. Experimental or Investigative drugs, drugs that may be dispensed without a prescription (such as aspirin), and over-the-counter products unless specifically included like OTC Prilosec and Loratadine as noted on p. 35.
17. Nondurable medical supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including, but not limited to, bandages, hypodermic syringes (except as appropriate when required for delivery of the drug prescribed), diapers, support garments, except at the discretion of the Board of Trustees when Medically Necessary.
18. Attorney fees relating to personal injury proceedings.
19. Hospital charges for confinement following the time the attending Physician approves discharge from the Hospital.
20. Eye exercise or vision training, but only when not medically necessary.
21. Artificial insemination, in vitro fertilization, gamete intra-fallopian transfer or any other procedure that attempts to promote fertility. However, this exclusion does not include procedures for the medical treatment of infertility due to sickness, injury or bodily defect except that artificial insemination, in vitro fertilization, gamete intra fallopian transfer or similar fertility promotion procedures or techniques will remain excluded from coverage even if part of this treatment.
22. Charges related to memberships in a health club, swimming programs, and physical fitness programs other than at a Hospital outpatient department.
23. Construction or a modification to a home, residence or vehicle required because of an injury, illness or disability.
24. Sex transformation.

25. Vasectomy reversal or tubal ligation reversal.
26. Routine foot care, including but not limited to trimming of toenails, removal of calluses, and preventive care.
27. Orthopedic shoes, except when attached to a brace and prescribed by a Physician.
28. Medical treatment from a Hospital or Physician that reimburses or waives the cost of transportation or provides other incentives for an individual to receive medical treatment, either within or outside the geographic jurisdiction of the Fund, if charges exceed the Reasonable and Customary charge for the treatment in the appropriate geographic area of the Plan. When determining the appropriate geographic area the Trustees will consider the geographic area where the covered individual normally would have received this type of medical treatment.
29. Chelation therapy except for any expense or charges for chelation therapy for acute arsenic, gold, mercury, or lead poisoning.
30. Claims that are submitted 24 months or later after the service was performed.
31. Charges in excess of the Reasonable and Customary charge.
32. Recreational therapy.
33. Marriage counseling, except as provided by the Employee Assistance Program at no additional charge.
34. Methadone treatments, including all related costs for administration of methadone, except where such methadone treatments are part of a treatment plan for eventual elimination of the dose. To be covered, all such treatment plans must be managed by T.E.A.M., Inc., the Employee Assistance Plan vendor employed by the Plan.
35. Acupuncture.
36. Subject to the January 1, 2010 Bariatric Surgery Benefit, medical or surgical treatment for weight reduction or obesity, including morbid or exogenous obesity. This exclusion includes, but is not limited to, dietary programs and surgical interventions. Examples of excluded procedures or treatments are gastric bypass, Roux-en-Y procedure, vertical banded gastroplasty, loop gastric bypass, simply gastroplasty, (more commonly known as stomach stapling), duodenal switch operation, biliopancreatic bypass (Scopinaro procedure), mini gastric bypass, implantable gastric stimulators and other weight loss surgeries. Also excluded from coverage is treatment required because of or arising from complications from a treatment or condition excluded by this paragraph.
37. Services from a Physician who does not meet the Plan's definition of Physician.
38. Treatment at halfway house.
39. Gambling addiction except as provided through the Employee Assistance Program at no additional charge.
40. Dental services or surgery, except as provided under the Major Medical provision of this SPD.
41. Smoking Cessation medication, except for what is provided under the BlueCross Smoking Cessation Program if you are enrolled.

BENEFIT CLAIMS AND APPEALS

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

How To File A Claim

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

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

- Retiree name;
- Patient name;
- Patient date of birth;
- Social Security Number of Retiree;
- Date of service;
- CPT-4 (the code for Physician services and other health care services found in the Current Procedural Terminology, Fourth Edition, as maintained and distributed by the American Medical Association);
- ICD-9 (the diagnosis code found in the International Classification of Diseases, 9th Edition, Clinical Modification as maintained and distributed by the U.S. Department of Health and Human Services);
- Billed charge;
- Number of units (for anesthesia and certain other claims);
- Federal taxpayer identification number (TIN) of the provider;
- Billing name and address; and
- If treatment is due to accident, accident details.

When Claims Must Be Filed

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

Where Claims Must Be Filed

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

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

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

Facility Of Payment Of Claims

Accrued claims unpaid at the Eligible Retiree's Death may, at the option of the Trustees, be paid either to the Eligible Retiree's beneficiary or to the Eligible Retiree's estate.

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

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

Physical Examinations And Autopsy

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

Discretionary Authority Of Fund Administrator

In carrying out their respective responsibilities under the Fund, the administrator and other Fund fiduciaries and individuals to whom responsibility for the administration of the Fund has been delegated, have discretionary authority to interpret the terms of the Fund and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to benefits in accordance with the terms of the Fund. Any interpretation or determination made under that discretionary authority will

be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Authorized Representatives

An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. You can obtain a form from the Fund's third-party administrator to designate an authorized representative. The Fund may request additional information to verify that this person is authorized to act on your behalf.

Assignment Of Benefits

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

Post Service Medical Claims

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

The following procedures apply to Post-Service Medical Claims:

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

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

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

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

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

Notice Of Denial of Claim or Adverse Benefit Determination

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

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

Your Right To Request A Review Of A Denied Claim

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

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

- It was relied upon by the Fund in making the decision;
- It was submitted, considered or generated in the course of making the benefit determination (regardless of whether it was relied upon);

- It demonstrates compliance with the Fund's administrative processes for ensuring consistent decision-making; or
- It constitutes a statement of Fund policy regarding the denied treatment or service.

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

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

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

Second Level Review – Appeal To The Board of Trustees

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

Notice Of Decision On Appeal

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

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

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

applying the terms of The Fund to your claim, or a statement that it is available upon request at no charge.

Legal Actions

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

PRIVACY POLICY

Effective April 14, 2003, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Fund's privacy notice, which will be distributed to you upon eligibility. The privacy notice is available from The Fund Office.

Effective April 14, 2003, this Fund will not use or further disclose information that is protected by HIPAA (protected health information) except as necessary for treatment, payment, health plan operations and Plan Administration, or as permitted or required by law. By law, the Fund will require all of its business associates to also observe HIPAA's privacy rules. In particular, the Fund will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or Employee Benefit Plan of the Fund.

Under HIPAA, effective April 14, 2003, you will have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You will also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Fund will maintain a privacy notice effective April 14, 2003 that provides a complete description of your rights under HIPAA's privacy rules. Please contact the Fund Administrator:

- For a copy of the notice;
- If you have questions about the privacy of your health information; or
- If you wish to file a complaint under HIPAA.

COORDINATION WITH OTHER BENEFITS

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

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

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

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

Effect On Benefits

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

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

Order Of Benefit Determination

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

- A plan without Coordination of Benefits rules will determine benefits before a plan that contains Coordination of Benefits rules.
- A plan that covers the claimant as an employee will determine benefits before a plan that covers the person as other than an employee.
- The Plan covering a person as a laid-off or retired employee, or as a Dependent of a laid-off or retired employee, will be secondary to the benefits of any other plan covering the person. This rule does not apply if the other plan does not have this rule.

- If an individual is covered as an employee under two plans, the Plan that has covered him or her longer is primary, and pays benefits first. However, when the individual is eligible under one plan as a currently working employee and under the other by bank hours or some other reserve accumulation system that continues eligibility, the Plan that covers the individual as a currently working employee will be primary and pay benefits first.
- For claims on behalf of Dependent children, the Plan that covers the parent whose birthday (month and day) falls earlier in the Calendar Year will determine benefits before the Plan of the parent whose birthday falls later in the year. If the parents have the same birthday, the Plan covering the parent for the longer period will determine benefits first.
- If one plan uses the gender rule and the other plan coordinates benefits using the birthday rule, the gender rule plan will determine the order of benefit payment. Under the gender rule, the Plan of the male Retiree determines benefits for Dependents before the Plan of the female employee.
- For Dependent children of separated or divorced parents:
  - Where there is a court decree that establishes financial responsibility for medical expenses, the Plan covering the parent who has the financial responsibility will determine benefits first.
  - If there is no court decree, the Plan that covers the custodial parent will determine benefits first.
  - If there is no court decree and the parent with custody has remarried, the order of benefits will be:
    - The Plan of the custodial parent will determine benefits first;
    - The Plan of the step-parent with custody will determine benefits next; and
    - The Plan of the non-custodial parent will determine benefits last.

COORDINATION WITH MEDICARE

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

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

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

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

The Medicare Coordination of Benefits rules apply before any other Coordination of Benefits rules of this Plan.

Order of Benefit Determination:

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

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

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

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

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

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

Effect On Benefits

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

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

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

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

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

SUBROGATION

The Plan will have a first priority right to recovery against any party or any source for your injury or sickness that created the need for the services and/or benefits for which the Plan paid, to the extent of the payment made by the Plan plus reasonable costs of collection, including reasonable attorney fees The Plan's claim for reimbursement will be paid in full before and it will take precedence over any claim for general or special damages by you. Any state law requiring you to be made whole before the Plan is entitled to reimbursement does not apply. The Plan's right to subrogation and reimbursement is not affected, reduced or eliminated by the "Make Whole Doctrine," comparative fault, regulatory diligence, or the "Common Fund Doctrine."

You must cooperate with the Plan in assisting it to protect its legal rights under this provision, and you must do nothing to prejudice the Plan's subrogation/reimbursement rights. The Plan, once benefits are paid, is granted an equitable lien on the proceeds of any payment, settlement, or judgment.

You will pay the amount of the Plan's subrogation/reimbursement claim to the Plan before you pay attorney fees and costs incurred in any litigation related to the recovery. The Plan does not agree to pay a share of your attorney fees in recovering the Plan's claim, unless the Board of Trustees otherwise agrees in writing with you and/or your attorney. The Plan may bring suit in your name and it may recover from you any proceeds of any settlement or judgment obtained from any party or source. Any such proceeds will be held by you in trust for the benefit of the Plan, and the Plan will be entitled to recover reasonable attorney fees it may incur in collecting any proceeds held by you.

To facilitate its right, the Plan may withhold benefits until you execute documents as the Plan requires. The Plan's payments of medical claims may be conditioned on your agreement in writing to:

- Reimburse the Plan to the extent of benefits paid by the Plan; and/or
- Provide the Plan with a lien to the extent of benefits provided to you by the Plan.

If you refuse to cooperate with the Plan's subrogation provisions, the Fund may offset your future claims until the Plan's subrogation rights have been satisfied.

You may not assign any rights or cause of action that you may have against any party to recover medical expenses without the express written consent of the Plan.

IMPORTANT INFORMATION ABOUT THE BENEFIT FUND

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

Fund Name
Sheet Metal #10 Benefit Fund.

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

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

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

As of July 1, 2010, the Trustees of this Fund are:

UNION TRUSTEES

Chris Malon
Sheet Metal Workers Local #10
1681 East Cope Avenue
St. Paul, MN 55109

Marty Strub
Sheet Metal Workers Local #10
1681 East Cope Avenue
St. Paul, MN 55109

Luigi Andretta
Sheet Metal Workers Local #10
1681 East Cope Avenue
St. Paul, MN 55109

Steven Raatikka
Sheet Metal Workers Local #10
1681 East Cope Avenue
St. Paul, MN 5510

Matthew Fairbanks, Alternate
Sheet Metal Workers Local #10
1681 East Cope Avenue
St. Paul, MN 55109

EMPLOYER TRUSTEES

Michael Jenson
General Sheet Metal Company, LLC
2330 Louisiana Ave. No.
Minneapolis, MN 55427

John Quarnstrom
SMARCA, Inc.
1405 Lilac Drive, Suite 100
Minneapolis, MN 55422

Thomas Lindskog
Carlson Air Conditioning
1203 Bryant Avenue North
Minneapolis, MN 55411

Gary Sohlstrom
Environ-Con, Inc.
500 Apollo Avenue, NE
St. Cloud, MN 56304

James Bigham, Alternate
SMARCA, Inc.
1405 Lilac Drive, Suite 100
Minneapolis, MN 55422

Identification Number

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

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

Plan Year

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

Agent For Service Of Legal Process

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

Source Of Contributions

The benefits provided by the Fund for benefits to Retirees are financed by Retiree payments.

Plan Type

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

Trust Fund

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

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

Benefits Mistakenly Paid

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

STATEMENT OF ERISA RIGHTS

As a Participant in the Sheet Metal #10 Benefit Fund, Retiree Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants are entitled to the rights described in this section.

Receive Information About Your Plan And Benefits

You have the right to:

1. Examine, without charge, at the Plan Administrator's office and other specified locations, such as Union halls and worksites at which at least 50 Plan Participants covered under the Plan customarily work, all Plan Documents, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
2. Obtain copies of all Plan Documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You also have the right to:

1. Continue health care coverage for your spouse or your Dependents if there is a loss of coverage under the Plan because of a qualifying event. Your spouse or your Dependents may have to pay for such coverage. Review this booklet and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.
2. Reduce or eliminate exclusionary periods of coverage for Pre-Existing Conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA Continuation Coverage, or when your COBRA Continuation Coverage ends. You must request it before losing coverage or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a Pre-Existing Condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other plan Participants and beneficiaries. No one, including your employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If a claim for benefits is denied, in whole or in part, you may file suit in a state or federal court. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and appeals procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

If you believe that Plan fiduciaries have misused the Plan's money, or if you believe that you have been discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the Employee Benefits Security Administration (EBSA) at:

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

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

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

APPENDIX

SCHEDULE OF BENEFITS

Retirees Who Retired Before November 1, 1977

Coverage	Benefit Amount
Medicare Part A Deductibles	100%
Medicare Part B Deductibles	100%
Calendar Year Deductible	$25
Prescription Drug Benefit	80% of Reasonable and Customary Charges after the deductible is satisfied.

MAXIMUM PAYMENT

The total lifetime payment for all covered charges incurred both before and after your eligibility for Medicare from the date of retirement will not exceed $20,000 for each Retired Employee and spouse. This includes benefits received under all Retiree Benefit programs under this Plan.