Sheet Metal #10 Benefit Fund

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

May 2023

IMPORTANT ANNOUNCEMENT FOR PLAN PARTICIPANTS

The declared National Emergency related to Covid-19 ends on Thursday May 11, 2023. The National Emergency had compelled the Plan to provide 100% coverage for certain Covid-19 services related to diagnostic testing, anti-virals, vaccines and over-the-counter test kits.

The end of the National Emergency will impact the coverage of those Covid-19 related medical benefits under the Plan. While coverage for most benefits continues, how the Plan will pay for those benefits is reflected in the table below:

Covid-19 Benefit	Current Plan Coverage	Plan Coverage as of May 12, 2023
Covid-19 Diagnostic Testing	100% coverage	Coverage continues subject to member cost-share (deductible/coinsurance)
Covid-19 Anti-Virals	100% coverage of dispensing fee.	Dispensing fee is subject to member cost-share
Covid-19 Vaccines	100% coverage	100% coverage as a routine immunization/vaccine
Covid-19 At-Home Test Kits	100% coverage of up to 8 OTC test kits per eligible person per month	No longer covered by the Plan. Member pays 100% of the cost

Sheet Metal #10 Benefit Fund

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December 2022

IMPORTANT ANNOUNCEMENT FOR ACTIVE PARTICIPANTS

Summary of Material Modifications

The Trustees of the Sheet Metal #10 Benefit Fund have amended the Plan to remove the temporary label from coverage for In-Network Telehealth visits.

1. **Effective January 1, 2023, Coverage for In-Network Telehealth Services is made a regular Plan benefit**:

Effective January 1, 2023, the Trustees are removing the temporary coverage label for In-Network Telehealth visits and making such In-Network visits a regular benefit under the Plan. Telehealth visits under this provision will be covered as an in-office visit under the Plan's terms and subject to the annual deductible and out-of-pocket maximum.

Out-of-Network telehealth visits, other than for COVID-19 related visits, are not covered by the Plan.

Important Note – Doctor on Demand:

The Plan's Doctor on Demand benefit remains the same. Specifically, any Telehealth visits via Doctor on Demand for any reason are covered at 100% and are not subject to the annual deductible or out-of-pocket maximum benefit.

Notice Regarding "Grandfathered" Status
This notice must accompany any Plan materials that are sent to participants.

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

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

Sheet Metal #10 Benefit Fund

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August 2022

IMPORTANT ANNOUNCEMENT FOR ACTIVE PARTICIPANTS

Summary of Material Modifications

The Trustees of the Sheet Metal #10 Benefit Fund have adopted the following amendments to the Active Plan. The amendments add physician's assistant to the definition of Physician and further provide that a physician's assistant can certify a disability under the Plan's Weekly Sickness and Accident Benefit. Additionally, the Plan has extended coverage for Non-Covid 19 In-Network telehealth visits. These changes are effective on the dates further detailed below.

1. **Effective July 1, 2022, the Plan's definition of Physician is amended to provide as follows:**

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

2. **Effective July 1, 2022, the first paragraph of the Plan's provisions on Weekly Sickness and Accident Benefits is amended to provide as follows:**

Eligible Employees Only

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

3. **Effective January 1, 2022, Coverage for In-Network Telehealth Services for Non-COVID-19 Visits is extended through December 31, 2022**:

Effective January 1, 2022, the Trustees are extending their temporary coverage of In-network Telehealth visits for Non-COVID-19 treatment through December 31, 2022. Telehealth visits under this temporary extension will be covered as an in-office visit under the Plan's terms and subject to the annual deductible and out-of-pocket maximum.

Out-of-network telehealth visits, other than for COVID-19 related visits, are not covered by the Plan.

This is another temporary extension of the coverage for in-network telehealth services that the Plan has previously adopted to assist all during the pandemic.

Important Note – Doctor on Demand:
The Plan's Doctor on Demand benefit remains the same. Specifically, any Telehealth visits via Doctor on Demand for any reason are covered at 100% and are not subject to the annual deductible or out-of-pocket maximum benefit.

4. **Effective August 1, 2022, the Plan has increased the Bariatric Surgery lifetime maximum benefit from $20,000 to $25,000 as provided below**:

Eligible Employees and Dependents **Major Medical Expense Benefit**	**Coverage – Plan A**	**Coverage – Plan B**
Bariatric Surgery Must be performed at a Blue Center of Distinction. (see page 53 for details and page 70 for an exclusion from coverage if requirements are not met)	$25,000 lifetime maximum	$25,000 lifetime maximum

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

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January 2022

IMPORTANT ANNOUNCEMENT FOR ACTIVE AND PRE-MEDICARE RETIRED PARTICIPANTS

Summary of Material Modifications

The Trustees of the Sheet Metal #10 Benefit Fund have adopted the following amendments to both the Active and Pre-Medicare Retiree Plans. The amendments serve to provide you notice on coverage of 1) At-Home Covid-19 Test Kits, 2) revise the Plan's definition of Medically Necessary or Medical Necessity, 3) adopt a policy of the Plan's Third-Party Administrator Wilson-McShane Corporation, regarding the Identification, Documentation, and Routing of Outpatient Drug Testing Claims Related to a Diagnosis of Substance Use Disorder for Medical Necessity Review, and 4) incorporate provisions to comply with the No Surprises Act

Each of the changes and their respective effective dates are detailed below.

1. Plan Coverage of At-Home Covid-19 Test Kits

Pursuant to recent U.S. Department of Labor guidance, the Plan will provide coverage for at-home Covid-19 tests subject to the following provisions.

- **When was coverage of at-home Covid-19 tests effective?** Covid-19 tests are covered if purchased on and after January 15, 2022, and through the end of the declared public health emergency related to Covid-19.

- **What is the best way to purchase the tests?** The best way for you to purchase a test is at your regular in-network Prime Therapeutics pharmacy. Be sure to purchase the tests at the pharmacy counter (rather than the main checkout) so that the claims can be properly processed by Prime Therapeutics.

    - **Please note that there are free at-home Covid-19 Tests available from the federal government:** Every home in the U.S. is eligible to order 4 free at-home Covid-19 tests. Go to www.COVIDtests.gov to order your free at-home Covid-19 tests.

- **How many tests are covered?** Coverage is provided for up to eight (8) tests per covered individual in a 30-day period. Coverage is provided through the Plan's prescription drug benefit program administered by Prime Therapeutics.

    - For example, a family of four covered under the Plan, may receive at no cost up to 32 tests (8 per covered person) in a 30-day period if purchased at an in-network provider.

- **What kind of tests are covered?** Only FDA-approved tests will be covered under this program. Be sure to check the packaging on the test to see that it is an FDA-approved test before purchasing.

- **Do I have to pay anything for the tests if I buy them in-network?** No. The Plan will cover the cost of at-home Covid-19 tests without cost-sharing (no deductible or coinsurance) for tests purchased directly or online at a Prime Therapeutics in-network pharmacy.

    - **Important note:** *For At-Home Covid-19 test purchases only*, CVS will be considered in-network. For all other pharmacy benefits, CVS will remain out-of-network with no coverage or reimbursement.

- **What if I purchased the tests out-of-network?** If you purchase tests from an out-of-network pharmacy, a non-pharmacy retailer, or the front counter of a participating pharmacy, your reimbursement will be the actual amount you paid per test or $12 per test, *whichever is less.* You must then submit for reimbursement of your expenses through Prime Therapeutics in the method listed below under *"What if I already bought and paid for tests on or after January 15, 2022, but before receiving this notice or if I purchased tests from a non-network provider or a non-pharmacy retailer?"*

- **What if I already bought and paid for tests on or after January 15, 2022, but before receiving this notice or if I purchased tests from a non-network provider or a non-pharmacy retailer?** If you purchased tests previously or purchased them from a non-network provider, a non-pharmacy retailer, or at the front counter of a participating pharmacy and have your receipts for the purchase, you can submit for reimbursement through the Plan's Administrator, Wilson-McShane Corporation. Attached is a claim form. Once completed, you can file it by mailing it to:

  Wilson-McShane Corporation
  3001 Metro Drive, Suite 500
  Bloomington, MN 55425
  Or by Fax: 952-851-3521

  Submitted forms must be completed in its entirety and will be processed for reimbursement in approximately 45 days.

- **Important note:** Covered at-home Covid-19 tests include only those for at-home medical use by you or your covered household family members. Tests for employment purposes, resale, or travel requirements will not be covered or reimbursed under this program.

2. **Effective January 1, 2022, the Plans have revised their definition of Medical Necessity to provide as follows:**

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

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

3. **Effective January 1, 2022, the Plan adopts Wilson-McShane Corporation's Policy for Medical Necessity Review of Outpatient Drug Testing Claims.**

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

4. **Effective January 1, 2022, the following provisions regarding the No Surprises Act are added to the end of the Major Medical Expense Benefit Section of each Plan:**

No Surprises Act

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

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

Balance Billing (sometimes called "surprise billing")

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in the Plan's Blue Cross Blue Shield network.

"Out-of-network" describes providers and facilities that haven't signed a provider agreement with Blue Cross Blue Shield. Out-of-network providers may be permitted to bill you for the difference between what the Plan agreed to pay, and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service.

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

You are protected from balance billing for:

Emergency services

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

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

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

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

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

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). The Plan will pay out-of-network providers and facilities directly.

- The Plan will:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what the Plan would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit under the Plan.

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

External Claim Appeals for No Surprises Act Claims Only

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

Standard External Review for Non-Urgent Claim

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

1. Within five (5) business days following the date of receipt of the external review request, the Plan Administrator will complete a preliminary review of the request to determine whether:

    a. You are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;

    b. The adverse benefit determination or the final adverse benefit determination is not based on the fact that you were not eligible under the Plan;

    c. You have exhausted the Plan's internal appeal process (unless exhaustion is not required); and

    d. You have provided all the information and forms required to process an external review.

2. Within 1 business day after completion of the preliminary review, the Plan Administrator will notify you in writing regarding whether your claim is eligible for external review. To be eligible for external review, the adverse appeal decision must be based upon a medical judgment, or it must involve a rescission of coverage. If your request was not complete, the notice will describe information or materials needed to complete request. You will have until the end of the 4-month period you had to file a request for an external review or 48 hours (whichever is later) to complete your request. If your request is complete but not eligible for external review, the notice will include the reasons your request was ineligible and contact information for the Employee Benefits Security Administration.

3. If the request is complete and eligible for external review, the Plan Administrator will assign an accredited independent review organization (IRO) to conduct the external review.

   a. The IRO will utilize legal experts where appropriate to make coverage determinations under the Plan and will notify you in writing of the request's eligibility and acceptance for external review. You may submit additional information in writing to the IRO within 10 business days that the IRO must consider when conducting the external review.

   b. The Plan Administrator will provide documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO.

   c. The IRO will review all the information and documents timely received and is not bound by the Plan Administrator's prior determination. The IRO may consider the following in reaching a decision:

      1) Your medical records;

      2) The attending health care professional's recommendation;

      3) Reports from appropriate health care professionals and other documents submitted by the Plan Administrator, you, or your treating provider;

      4) The terms of the Plan;

      5) Evidence-based practice guidelines;

      6) Any applicable clinical review criteria developed and used by the Plan Administrator; and

      7) The opinion of the IRO's clinical reviewer or reviewers after considering information noted above as appropriate.

   d. The IRO will provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision.

Expedited External Review

1. You may request an expedited external review when you receive:

   a. An adverse benefit determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

   b. A final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or

health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

2. Immediately upon receipt of the request for expedited external review, the Plan Administrator will determine whether the request meets the reviewability requirements noted above for standard external review and will notify you of its eligibility determination.

3. When the Plan Administrator determines that your request is eligible for external review an IRO will be assigned. The Plan Administrator will provide all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO by any available expeditious method.

4. The IRO must consider the information or documents provided and is not bound by the Plan Administrator's prior determination. The IRO will provide notice of the final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the IRO's notice is not in writing, the IRO must provide written confirmation of the decision within 48 hours to the claimant and the Plan.

Notice Regarding "Grandfathered" Status

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

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

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

SHEET METAL #10 BENEFIT FUND

COVID-19 OVER THE COUNTER AT-HOME TESTING REIMBURSEMENT FORM

A SEPARATE CLAIM FORM MUST BE SUBMITTED FOR EACH PERSON COVERED UNDER THE PLAN

Please use this form to request reimbursement of your COVID-19 Over the Counter (OTC) At-Home Test.

To be eligible, the following criteria must apply:

- The at-home test must be approved for use under the Emergency Use Authority (EUA) of the FDA.
- Only for COVID-19 OTC tests purchased on or after 1/15/2022 and through the end of the COVID-19 Federal Public Health Emergency (PHE), as determined by the Secretary of Health and Human Services.
- Reimbursement is limited to eight (8) tests per participant or dependent under the Plan in a thirty-day period, with the initial thirty-day period beginning on 1/15/22. Each covered participant or dependent must submit a separate claim form to receive reimbursement. If you receive tests with a $0 copay from a Prime Therapeutics in-network pharmacy it counts against the eight (8) test limit.
- Reimbursement is limited to the lesser of the actual cost of the test or $12.00 for tests purchased out-of-network (*i.e.*, tests that are not purchased through the Prime Therapeutics pharmacy network).

GROUP #102796

Participant information:		
Last Name:	First Name:	ID#:
Participant: ☐	Dependent: ☐ Name:	
Date of Birth:	Is testing for employment purposes:	Yes ☐ No ☐
Street address:	City:	State and Zip Code:
Phone No:	E-Mail:	

How to submit your claim:

1. Complete all applicable blanks on the form.
2. Attach a copy of the itemized receipt. The itemized receipt must include:
   - Name of vendor the test was purchased from,
   - UPC – the Universal Product Code or UPC is usually found on the back of the product,
   - Date(s) of purchase,
   - Number of tests purchased, and
   - Individual charge for each COVID-19 OTC test purchased.
3. If you have other health care coverage primary to your Sheet Metal #10 Benefit Fund coverage, submit a claim to your primary Plan first. Then, when you submit this claim, include a copy of the Explanation of Health Care Benefits you received from your primary coverage.

Note: There will be delays of up to 45 days in sending out reimbursement checks due to Wilson-McShane Corporation coordinating with in-network pharmacies to ensure that no more than eight (8) tests per 30 days are covered.

Mail this form to: Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425

Fax: 952-851-3521

I certify that the COVID-19 OTC test(s) I am requesting reimbursement for are for personal use, are not for employment purposes, travel, return to work, have not been (and will not be) reimbursed by another source, and are not for resale. I attest that the statements provided by me are correct and acknowledge that I will refund the Sheet Metal #10 Benefit Fund duplicate payments to myself (if any) because of coordination of benefits.

Signature:_____ Date signed _____

Sheet Metal #10 Benefit Fund

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June 2021

IMPORTANT ANNOUNCEMENT FOR ACTIVE PARTICIPANTS

Summary of Material Modifications

The Trustees of the Sheet Metal #10 Benefit Fund announce the following changes to the Active Plan and the provisions for the Dollar Bank.

1. **The Plan's provisions on the maximum accrual allowed in your Dollar Bank on Page 24 of the Plan are amended to provide as follows:**

Dollar Bank

....

Under your Dollar Bank, you may accrue up to the following maximum amounts:

Year	Dollar Bank Maximum
8/1/2021	$35,000*

*As of August 1, 2021, the maximum you can accrue in your Dollar Bank is $35,000. When funding your Dollar Bank from $30,000 to $35,000, 50% of the contributions made on your behalf beyond the full cost of coverage will be credited to your dollar bank. This will continue until your balance reaches the maximum amount of $35,000. Please note that your Dollar Bank is not a vested benefit.

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December 2020

IMPORTANT ANNOUNCEMENT FOR ACTIVE AND PRE-MEDICARE RETIRED PARTICIPANTS

Summary of Material Modifications

The Trustees of the Sheet Metal #10 Benefit Fund announce the following changes to the Plans for both Active and Pre-Medicare Retired Participants. The changes are effective January 1, 2021.

The Plan changes relate to coverage of Telehealth Services provided by in-network providers.

Telehealth Services

Effective January 1, 2021 through December 31, 2021, In-Network Telehealth visits will continue to be covered the same as an in-office doctor's visit subject to the annual deductible and out-of-pocket maximums as detailed in the Schedule of Benefits.

Out-of-network Telehealth visits are not covered by the Plan.

This is another temporary extension of the coverage for in-network telehealth services that the Plan has previously adopted in an effort to assist all during the pandemic.

Important Note – Doctor on Demand:

The Plan's Doctor on Demand benefit remains the same. Specifically, any Telehealth visits via Doctor on Demand for any reason are covered at 100% and are not subject to the annual deductible or out-of-pocket maximum benefit.

Notice Regarding "Grandfathered" Status

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Sheet Metal #10 Benefit Fund

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

December 2020

IMPORTANT ANNOUNCEMENT FOR ACTIVE AND PRE-MEDICARE RETIRED PARTICIPANTS

Summary of Material Modifications

The Trustees of the Sheet Metal #10 Benefit Fund announce the following changes to the Plans for both Active and Pre-Medicare Retired Participants.

The changes relate to coverage of Covid-19 vaccines and testing. These changes are effective immediately.

- **COVID-19 Vaccine Coverage:** The Plan will provide coverage at 100% with no cost-sharing for administration of a COVID-19 Vaccine at any location in which you can obtain the vaccine (doctor's office, retail clinic or pharmacy).

  This change applies only to coverage of the COVID-19 Vaccine. The Plan's coverage provisions related to other immunizations and how they are covered as described in the Plan's Schedule of Benefits remain unchanged.

- **COVID-19 Testing Coverage:** COVID-19 testing continues to be covered at 100% by the Plan and will remain covered for the duration of the nationally declared Public Health Emergency (PHE). The PHE currently runs through January 22, 2021 but it is expected that it may be extended further by the federal Department of Health and Human Services.

Please contact Wilson McShane at 952-854-0795 with any questions regarding these changes.

Notice Regarding "Grandfathered" Status

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

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

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

Sheet Metal #10 Benefit Fund

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

May 2020

IMPORTANT ANNOUNCEMENT FOR ACTIVE AND PRE-MEDICARE RETIRED PARTICIPANTS

Summary of Material Modifications

The Trustees of the Sheet Metal #10 Benefit Fund announce the following changes to the Plans for both Active and Pre-Medicare Retired Participants. The changes relate to coverage of Telehealth Services for Non-COVID-19 Related visits.

Please be reminded that the Plan was recently amended effective March 18, 2020 regarding Telehealth visits. The amendment provided 100% coverage for COVID-19 related Telehealth visits through December 31, 2020 and for Non-COVID-19 the Plan was amended to provide 100% coverage through June 30, 2020.

Telehealth-Non-COVID-19

The Plan is now being amended regarding Telehealth for Non-COVID-19 visits effective July 1, 2020.

Effective July 1, 2020 through December 31, 2020, In-Network Telehealth visits for Non-COVID-19 related reasons are covered the same as an in-office doctor's visit subject to the annual deductible and out-of-pocket maximums as detailed in the Schedule of Benefits.

Out-of-network Telehealth visits, other than for COVID-19 related visits, are not covered by the Plan.

Important Note:

The Plan's Doctor on Demand benefit remains the same. Specifically, any Telehealth visits via Doctor on Demand for any reason are covered at 100% and are not subject to the annual deductible or out-of-pocket maximum benefit.

Sheet Metal #10 Benefit Fund

OFFICE OF THE ADMINISTRATOR
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651-770-0991 Fax 651-770-1351 1-800-396-2903

April 2020

IMPORTANT ANNOUNCEMENT
FOR
ACTIVE PARTICIPANTS

Summary of Material Modifications

The Trustees of the Sheet Metal #10 Benefit Fund announce the following changes to the Plan's provisions for Annual Deductible and Out-of-Pocket Maximum for Active Participants in Plan A and B. The changes are effective July 1, 2020.

1. Schedule of Benefits – Annual Deductible Page 3

The Plan has increased its Annual Deductible effective July 1, 2020 as further indicated below:

Eligible Employees and Dependents Major Medical Expense Benefit *(See pages 47 – 55 for a listing of services covered as Major Medical Expenses)*	Coverage – Plan A	Coverage – Plan B
Annual Deductible Before the Plan pays for most covered expenses, you pay	$145 per person each year; $435 family maximum	$645 per person each year; $1,935 family maximum

2. Schedule of Benefits – Annual Out-of-Pocket Maximum Page 4

The Plan has increased its Annual Out-of-Pocket Maximum effective July 1, 2020 as further indicated below:

Eligible Employees and Dependents Major Medical Expense Benefit	Coverage – Plan A	Coverage – Plan B
Annual Out-of-Pocket Maximum Plan Pays 100% of covered charges for the remainder of the year, once you reach your Out-of-Pocket Maximum: Individual Out-of-Pocket Maximum Family Out-of-Pocket Maximum Annual Out-of-Pocket Maximum does not include your deductible.	$1,160 per person; $3,480 family maximum	$1,935 per person; $5,805 family maximum

STATEMENT OF NONDISCRIMINATION

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

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

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

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

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

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

Minnesota/North Dakota/South Dakota Languages

Language	Translation
English	Attention: If you speak (insert language), language assistance services, free of charge, are available to you. Call 1-952-854-0795.
Spanish	Atención: Si usted habla (español), tenemos disponible para usted el servicio de ayuda en su idioma sin costo alguno. Llame al 1-952-854-0795.
Hmong	Faj Seeb: Yog hais tias koj hais (Hmoob), kev pab cuam pab txhais lus, dawb tsis tau them, yeej muaj muab rau koj. Hu 1-952854-0795.
Cushite	Hubachiisa: Yoo kan afaan Oromoo dubbattan ta'e tajaajilli gargaarsa hiikoo afaanii ni argattu. Lakk. 1-952-854-0795 tiin bilbilaa.
Vietnamese	Nếu quý vị nói (tiếng Việt), chúng tôi có dịch vụ hỗ trợ ngôn ngữ sẵn sàng phục vụ quý vị miễn phí. Vui lòng gọi: 1-952-854-0795
Chinese	请注意：如果您讲中文，则您可以获得免费的语言协助服务。请致电：1-952-854-0795。

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

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Sheet Metal #10 Benefit Fund

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

March 2020

IMPORTANT ANNOUNCEMENT FOR ACTIVE AND PRE-MEDICARE RETIRED PARTICIPANTS

Summary of Material Modifications

The Trustees of the Sheet Metal #10 Benefit Fund announce the following changes to the Plans for both Active and Pre-Medicare Retired Participants. The changes relate to coverage of certain services related to COVID-19. These changes are effective March 18, 2020.

Specifically, the Plans have extended coverage at 100% with no cost-sharing as follows:

COVID-19 Testing

- The Plan will cover 100% of the cost:
  - For in vitro diagnostic testing for the COVID-19 virus that is either:
    - authorized by the FDA, or
    - otherwise specifically authorized by federal law or regulation.

    A covered test is referred to herein as a "COVID-19 Test";
  - For evaluation by a healthcare provider to determine whether you need a COVID-19 Test; and,
  - For services to administer a COVID-19 Test.
- Coverage for this amendment applies without regard to whether the COVID-19 Test is provided in-network or out-of-network. For out-of-network charges, the Plan will cover the full billed amount regardless of whether the amount exceeds the reasonable and customary amount. No prior authorization or medical management requirements apply to in vitro diagnostic testing for the COVID-19 virus. Coverage under this amendment applies without regard to the site of care (e.g., office, urgent care, emergency room, e-visits). The coverage under this amendment does not apply to any items and services you receive during a visit to a healthcare provider other than those expressly described above.
- Participants are strongly encouraged to contact their doctor for guidance before seeking COVID-19 testing.
- Coverage for this amendment applies through December 31, 2020.

Telehealth Services Related to COVID-19

The Plan currently covers telehealth medical visits through Doctor on Demand at 100%.

Telehealth – COVID-19 Related Visits: Effective March 18, 2020, the Trustees are temporarily expanding the Plan's telehealth visit benefit for COVID-19 related visits. Specifically, the Plan will cover telehealth medical visits related to COVID-19 at 100% regardless of whether the provider is in or out-of-network. This temporary expansion of coverage for COVID-19 telehealth visits will last through December 31, 2020.

Telehealth – Non-COVID-19 Visits: Effective March 18, 2020, the Trustees are temporarily expanding the Plan's telehealth benefit to provide 100% coverage with no cost-sharing for all in-network medical and behavioral health visits not associated with the diagnosis of COVID-19. Out-of-network telehealth visits, other than for COVID-19 related visits, are not covered by the Plan. This temporary expansion of the telehealth benefit will remain in effect through June 30, 2020.

Participants are strongly encouraged to contact their doctor for guidance before seeking COVID-19 testing.

COVID-19 Information

The available information about how the virus that causes COVID-19 spread is largely based on what is known about similar coronaviruses. However, COVID-19 is a new disease and there is more to learn about its transmission, the severity of illness it causes, and to what extent it may spread in the United States. According to the CDC, a person may develop symptoms of the COVID-19 virus within 14 days of exposure. Symptoms include feeling sick with an acute respiratory illness, such as a fever, cough, or difficulty breathing. As there is no present vaccine to prevent COVID-19, the CDC recommends the following to prevent the spread of the virus:

1. Wash hands often with soap and water for at least 20 seconds, and if soap and water are not available, use an alcohol-based hand sanitizer with at least 60% alcohol;

2. Avoid touching eyes, nose, and mouth with unwashed hands;

3. Avoid close contact with people who are sick;

4. Stay home when sick;

5. Cover coughs or sneezes with tissues or cough into the elbow area, then discard the tissue in the trash and follow up with handwashing; and

6. Clean and disinfect frequently touched objects and surfaces regularly

More information about COVID-19 may be found at the following links:

- Centers for Disease Control and Prevention: www.cdc.gov
- Minnesota Department of Health: https://www.health.state.mn.us/
- MN Building Trades: https://mntrades.org/covid-19-resources/
- World Health Organization: https://www.who.int
- Doctor on Demand (self-assessment tool): https://www.doctorondemand.com/coronavirus

Members are encouraged to visit the Plan's website at http://smw10.org/Benefits for further updates.

Sheet Metal #10 Benefit Fund

OFFICE OF THE ADMINISTRATOR
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651-770-0991 Fax 651-770-1351 1-800-396-2903

January 2020

IMPORTANT ANNOUNCEMENT FOR ACTIVE PARTICIPANTS

Summary of Material Modifications

The Trustees of the Sheet Metal #10 Benefit Fund announce the following changes to the Plan for Active Participants. The changes are effective January 1, 2020.

1. Schedule of Benefits – Dental Benefits – Page 8

The Plan has amended its Dental Benefits Schedule to provide for a two-year deductible and increased the benefit maximum every two calendar years as further indicated below:

Dental Care Benefit (see page 59)	Coverage – Plan A	Coverage – Plan B
Deductible every two Calendar Years (Coverage B, C and D Services) Individual Family Note: Deductible does not apply for individuals under age 19.	 $50 $150	 $50 $150
Maximum every two Calendar Years This maximum will not apply to an individual under age 19 for Dental Care Benefits under Coverage A, B and C.	$3,000	$3,000
Lifetime Maximum for Coverage D services (unless medically necessary). This maximum will not apply to an individual under age 19 for non-cosmetic orthodontic services.	$3,000	$3,000

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    - Information written in other languages

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

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Minnesota/North Dakota/South Dakota Languages

Language	Translation
English	Attention: If you speak (insert language), language assistance services, free of charge, are available to you. Call 1-952-854-0795.
Spanish	Atención: Si usted habla (español), tenemos disponible para usted el servicio de ayuda en su idioma sin costo alguno. Llame al 1-952-854-0795.
Hmong	Faj Seeb: Yog hais tias koj hais (Hmoob), kev pab cuam pab txhais lus, dawb tsis tau them, yeej muaj muab rau koj. Hu 1-952854-0795.
Cushite	Hubachiisa: Yoo kan afaan Oromoo dubbattan ta'e tajaajilli gargaarsa hiikoo afaanii ni argattu. Lakk. 1-952-854-0795 tiin bilbilaa.
Vietnamese	Nếu quý vị nói (tiếng Việt), chúng tôi có dịch vụ hỗ trợ ngôn ngữ sẵn sàng phục vụ quý vị miễn phí. Vui lòng gọi: 1-952-854-0795
Chinese	请注意：如果您讲中文，则您可以获得免费的语言协助服务。请致电：1-952-854-0795。
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Laotian	ໝາຍເຫດ ຖ້າທ່ານເວົ້າພາສາລາວ, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ໂດຍບໍ່ເສັຽຄ່າ ໃຫ້ແກ່ທ່ານ ໂທຫາ 1-952-854-0795.
Amharic	ማሳሰቢያ: የሚናገሩት (አማረኛ) ቋንቋ ከሆነ ከክፍያ ነጻ የሆነ የቋንቋ እገዛ አገልግሎት ማግኘት ይችላሉ። በስልክ ቁጥር 1-952-854-0795 ይደውሉ።
Karen	w>'k;oh.ng=erh>uwdR (unDusdm)< usdmw>rRpXRw>zH;w>rRwz.< vXwvXmbl;vJ< td.vXe*D>M.vDRI ud;vD wJpdql 1-952-854-0795 wuh>I
German	Hinweis: Wenn Sie (Deutsche) sprechen, stehen Ihnen kostenlose Sprachhilfsdienste zur Verfügung. Rufen Sie unter 1-952-854-0795 an.
Cambodian	□□□□□□ □□□□□□□□□□□□□□□□□□ (□□□□□□□□□□) □□ □□□ □□□□□□□□□□□□□□ 1-952-854-0795 □
Arabic	ملاحظة: إذا كنت تتحدث (العربية)، فيرجى العلم بأنه يمكنك الاستفادة من خدمات المساعدة اللغوية مجانًا. اتصل بالرقم: 1-952-854-0795.
French	Attention : Si vous parlez (Français), des services langagiers vous sont offerts gratuitement. Veuillez composez le 1-952-854-0795.
Korean	참고: 한국어 지원 서비스를 무료로 제공합니다. 문의전화 1-952-854-0795
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Sheet Metal #10 Benefit Fund

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

January 2019

IMPORTANT ANNOUNCEMENT FOR ACTIVE PARTICIPANTS

Summary of Material Modifications

The Trustees of the Sheet Metal #10 Benefit Fund announce the following changes to the Plan for Active Participants. The changes are effective March 1, 2019.

1. Prescription Drug Benefit – Pages 56-58

The following provisions regarding the Prime Therapeutics Classic Network, prior authorization, and quantity level limits, are added to the end of the provisions for Prescription Drug Benefits on Page 58.

Prime Therapeutics Classic Network

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

The Classic Network includes all Walgreens pharmacies, many chain pharmacies as well as independent pharmacies. The Prime Classic Network excludes certain other independent pharmacies and certain other national pharmacy chains such as CVS. This means if you currently have prescriptions filled at CVS (or other non-network pharmacy) you will have to make a change. You can determine if your pharmacy is in the Classic Network by visiting www.MyPrime.com.

Prior Authorization

The Plan has implemented a prior authorization program applicable to certain subset of prescription drugs. Prior authorization is required on these medications before your prescription will be covered by the Plan. If your prescription drug requires prior authorization, your physician must submit a prior authorization request form to Prime Therapeutics for approval.

- If authorization is granted, your prescription will be filled.
- If authorization is not granted, you have two choices:
    - You may still have the prescription filled by paying the entire retail cost of the prescription drug yourself; or

- You may ask your doctor to prescribe an alternate drug covered by the Plan, if available.

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

Quantity Level Limit Program

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

If you have questions regarding these changes to the Plan's Prescription Drug Benefit, you can contact Wilson McShane at 1-800-535-6373.

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  - Information written in other languages

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

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

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

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

Minnesota/North Dakota/South Dakota Languages

Language	Translation
English	Attention: If you speak (insert language), language assistance services, free of charge, are available to you. Call 1-952-854-0795.
Spanish	Atención: Si usted habla (español), tenemos disponible para usted el servicio de ayuda en su idioma sin costo alguno. Llame al 1-952-854-0795.
Hmong	Faj Seeb: Yog hais tias koj hais (Hmoob), kev pab cuam pab txhais lus, dawb tsis tau them, yeej muaj muab rau koj. Hu 1-952854-0795.
Cushite	Hubachiisa: Yoo kan afaan Oromoo dubbattan ta'e tajaajilli gargaarsa hiikoo afaanii ni argattu. Lakk. 1-952-854-0795 tiin bilbilaa.
Vietnamese	Nếu quý vị nói (tiếng Việt), chúng tôi có dịch vụ hỗ trợ ngôn ngữ sẵn sàng phục vụ quý vị miễn phí. Vui lòng gọi: 1-952-854-0795
Chinese	请注意：如果您讲中文，则您可以获得免费的语言协助服务。请致电：1-952-854-0795。
Russian	Внимание: Если Вы говорите на (Русском), услуги лингвистической поддержки доступны Вам бесплатно. Звоните 1-952-854-0795.
Laotian	ໝາຍເຫດ: ຖ້າທ່ານເວົ້າພາສາລາວ, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. ໂທຫາ 1-952-854-0795.
Amharic	ማሳሰቢያ: የሚናገሩት (አማረኛ) ቋንቋ ከሆነ ከክፍያ ነጻ የሆነ የቋንቋ እገዛ አገልግሎት ማግኘት ይችላሉ። በስልክ ቁጥር 1-952-854-0795 ይደውሉ።
Karen	w>'k;oh.ng=erh>uwdR (unDusdm)< usdmw>rRpXRw>zH;w>rRwz.< vXwvXmbl;vJ< td.vXe*D>M.vDRI ud;vD wJpdql 1-952-854-0795 wuh>I
German	Hinweis: Wenn Sie (Deutsche) sprechen, stehen Ihnen kostenlose Sprachhilfsdienste zur Verfügung. Rufen Sie unter 1-952-854-0795 an.
Cambodian	ចំណាំ៖ ប្រសិនបើអ្នកនិយាយ (ភាសាខ្មែរ) សេវាកម្មជំនួយខាងភាសាដោយឥតគិតថ្លៃនឹងមានសម្រាប់អ្នក។ សូម ទូរស័ព្ទទៅកាន់ 1-952-854-0795 ។
Arabic	ملاحظة: إذا كنت تتحدث (العربية)، فيرجى العلم بأنه يمكنك الاستفادة من خدمات المساعدة اللغوية مجانًا. اتصل بالرقم: 1-952-854-0795.
French	Attention : Si vous parlez (Français), des services langagiers vous sont offerts gratuitement. Veuillez composez le 1-952-854-0795.
Korean	참고: 한국어 지원 서비스를 무료로 제공합니다. 문의전화 1-952-854-0795

Tagalog

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

Notice Regarding "Grandfathered" Status

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

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

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