

AMENDMENT NO. 7 TO THE SHEET METAL WORKERS
LOCAL 268 WELFARE PLAN SUMMARY PLAN DESCRIPTION
(Effective July 1, 2017)

Effective March 1, 2020, the Trustees of the Sheet Metal Workers Local 268 Welfare Plan hereby amend the Plan Document and Summary Plan Description (“SPD”) in the manner set forth below.

The following **NOTE** shall be added to the end of the **Schedule of Medical Benefits** in Section C. 2.:

NOTE: Effective March 1, 2020 and until such time as determined by the Trustees in accordance with applicable law, COVID-19 testing performed by PPO and Out-of-Network providers shall be covered at 100% with no co-pay and no deductible as long as such testing is:

- Medically Necessary,
- consistent with guidelines established by the Centers for Disease Control and Prevention (CDC), and
- not covered by the CDC or a state program or agency.

In addition, the cost of the initial physician’s office, emergency room or urgent care visit that results in an order for testing for COVID-19 shall be covered at 100% with no co-pay and no deductible. Treatment for COVID-19 will remain at the normal Plan benefit as stated herein.

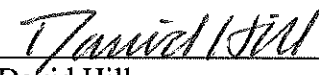
IN WITNESS WHEREOF, the Plan is amended as of the date set forth above.

UNION/EMPLOYEE TRUSTEES

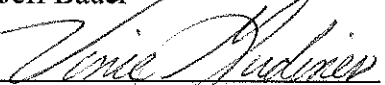
EMPLOYER TRUSTEES



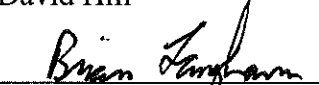
Jeff Bauer 07/07/2020
Date




David Hill 7/7/2020
Date




Vincent Gudines 07/07/2020
Date



Brian Langhauser 7-24-2020
Date



Mark Endrizzi 07/07/2020
Date



Nathan Allen 7/7/2020
Date

AMENDMENT NO. 9 TO THE SHEET METAL WORKERS LOCAL 268
WELFARE PLAN SUMMARY PLAN DESCRIPTION

Effective July 1, 2020, the Trustees of the Sheet Metal Workers Local 268 Welfare Plan hereby amend the Plan Document and Summary Plan Description ("SPD") in the manner set forth below.

1. In Section C.1.a. the fourth paragraph is revised to read as follows:

The Plan uses the Aetna Choice POS II Network (also known as the Aetna Choice POS II & MO IL Coventry Migration Network). Providers in that network ("Participating Providers") offer incentives over the use of Out-of-Network Providers.

2. All references to "Tier 1" providers or benefits throughout the document are changed to read "Participating Provider(s)" or "Participating Provider benefits".

3. Section C.1.b. is deleted in its entirety and is replaced as shown in Exhibit A.

4. The benefit for Ambulance Services shown in the Schedule of Medical Benefits is revised to read as follows:

BENEFIT	PARTICIPATING PROVIDER	OUT OF NETWORK/ NON-PARTICIPATING PROVIDER
Ambulance Service	After deductible is met, 90% coinsurance applies.	After deductible is met, 70% of up to 300% of Medicare Allowable Rate coinsurance (U&C does not apply).


IN WITNESS WHEREOF, the Plan is amended as of the date set forth above.

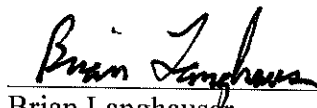
UNION/EMPLOYEE TRUSTEES

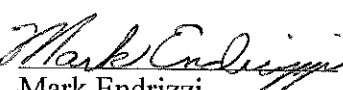
EMPLOYER TRUSTEES


Jeff Bauer 07/07/2020
Date


David Hill 7/7/2020
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Vincent Guidines 07/07/2020
Date


Brian Langhauser 7-24-2020
Date


Mark Endrizzi 07/07/2020
Date

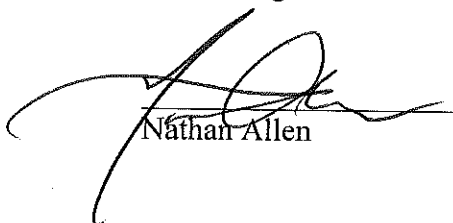

Nathan Allen 7/7/2020
Date

EXHIBIT A

MEDICAL MANAGEMENT PROGRAM

Medical Management is a program designed to help ensure that you and your eligible Dependents receive necessary and appropriate healthcare while avoiding unnecessary expenses. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other healthcare provider. The Medical Management Program Administrator contact information for this Plan is identified on the Employee identification card and also on the General Plan Information page of this Plan:

Precertification

Before you or your eligible Dependents are admitted to a medical facility or receive items or services from the list below, the Medical Management Program Administrator will, based on clinical information from the provider or facility, certify the care according to the Medical Management Program Administrator's policies, procedures and guidelines. Once an Inpatient setting has been precertified, working directly with your Physician, the Medical Management Program Administrator will identify and approve the most appropriate and cost-effective setting for the treatment as it progresses. The Medical Management Program Administrator will also assist and coordinate the initial implementation of any services you will need post hospitalization (called discharge planning) with the attending Physician and the facility. This could include registering you for specialized programs or case management when appropriate.

Your provider may precertify your treatment for you; however, you should verify prior to incurring Covered Expenses that your provider has obtained precertification. If your treatment is not precertified by you or your provider within the time periods described below a retrospective review may be performed. A retrospective review (as directed by the Plan) will determine if the services were Medically Necessary and would have been approved had the required phone call been made, provided the Covered Expenses meets all other Plan provisions and requirements. However, any charges not deemed Medically Necessary will be denied.

Case Management

Depending on the level of care needed, the case manager will coordinate and implement the case management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. All parties involved (e.g., the Plan, attending Physician, and patient) must all agree to the alternate individually tailored treatment plan. Each treatment plan is specific to that patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis. Case management is a voluntary service. There are no reductions of benefits or penalties if you or your eligible dependents choose not to participate.

Important Timeframes to Know

You, your Physician, the Facility or someone acting on your behalf, should call the Medical Management Program Administrator (at the number listed on your Employee identification card or the General Plan Information page of this Plan) within the following time frames for a:

Non-emergency admission	48 hours <u>before</u> the scheduled admission
Non-emergency services	48 hours <u>before</u> you are scheduled to receive the services
Emergency admission	Within 48 hours or if later, the next business day <u>after</u> you are admitted

If the attending Physician feels that it is Medically Necessary for a patient to receive services for a greater length of time than initially precertified, the attending Physician or the medical facility should request the additional service or days as soon as reasonably possible, but no later than the final authorized day.

List of Items and/or Services that require Precertification

The below items and/or services, if Covered Expenses under the Plan, should be precertified before any medical services are provided. To determine whether a benefit is covered or excluded, please review the Eligible Medical Expenses and/or General Exclusions and Limitations sections of your Plan.

All Inpatient Admissions:

- Acute
- Long-Term Acute Care
- Rehabilitation Facility
- Mental Disorder I Substance Use Disorder
- Residential Treatment Facility
- Transplant
- Skilled Nursing Facility

Diagnostic Services (Outpatient and Physician):

- CT for non-orthopedic
- MRI for non-orthopedic
- PET
- Capsule endoscopy
- Genetic testing, including BRCA
- Sleep study

Surgery (including in a Physician's office):

- Breast and bone marrow biopsy
- Biopsies (excluding skin)
- Vascular Access Devices for the infusion of chemotherapy (including, but not limited to, PICC and Central Lines)
- Thyroidectomy, partial or complete
- Open prostatectomy
- Creation and revision of Arteriovenous Fistula (AV Fistula) or Vessel to Vessel Cannula for dialysis
- Oophorectomy, unilateral and bilateral
- Back Surgeries and hardware related to Surgery
- Osteochondral Allograft, knee
- Hysterectomy (including prophylactic)
- Autologous chondrocyte implantation, Carticel
- Transplant (excluding cornea)
- Balloon sinuplasty
- Sleep apnea related Surgeries, limited to:
 - Radiofrequency ablation (Coblation, Somnoplasty)
 - Uvulopalatopharyngoplasty (UPPP), including laser-assisted procedures

Continuing Care Services (Outpatient and Physician):

- Chemotherapy (including oral)
- Radiation therapy
- Oncology and transplant related injections, infusions and treatments (e.g., CAR-T, endocrine and immunotherapy), excluding supportive drugs (e.g., antiemetic and antihistamine)
- Dialysis
- Hyperbaric oxygen
- Home health care
- Durable Medical Equipment, limited to electric/motorized scooters or wheelchairs and pneumatic compression devices

Monthly High Cost Drugs that are \$2,000 or more and are:

- Injectables
- Infusion therapies

Important Notes:

- * Precertification is recommended if a procedure could be considered Experimental and/or Investigational or potentially Cosmetic in nature (such as, but not limited to: abdominoplasty, cervicoplasty, liposuction/lipectomy, mammoplasty (augmentation and reduction - includes removal of implant), Morbid Obesity procedures, septoplasty, etc.).
- * Precertification is NOT REQUIRED for a maternity delivery admission, unless the stay extends past 48 hours for vaginal delivery or 96 hours for a cesarean section. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth. If a newborn remains hospitalized beyond the time frames specified, the confinement should be precertified with the Medical Management Program Administrator.
- * High Cost Drugs are drugs that are covered under the medical benefits section of the Plan. This requirement does not apply to drugs covered under the Prescription Drug Card Program.

Precertification Does Not Guarantee Payment

Precertification of the above benefits ensures the service being rendered is Medically Necessary and appropriate. All benefits/payments are subject to the patient's eligibility for benefits under the Plan. For benefit payment; services rendered must be considered a Covered Expense and are subject to all other provisions of the Plan.

To File a Complaint or Request an Appeal to a Non-Certification

If it is determined that the item and/or services are not Medically Necessary, the notification you receive will explain why. Verbal appeal requests and information regarding the appeal process should be directed to the Medical Management Program Administrator as identified on the General Plan Information page of this Plan.

High Cost Drug Management

The primary objective of the High Cost Drug Management program is to provide assistance when you or eligible dependents have been prescribed a high cost drug that exceeds \$2,000 per month and is covered under the medical benefits section of the Plan.

The High Cost Drug Management program helps coordinate the most effective way to reduce expenses associated with the high cost drug. Specially trained case managers will make recommendations based on the terms of the Plan to ensure the medication is being obtained through the most cost effective method.

If you or your eligible dependents are not currently utilizing the most cost effective method, the case manager will make a recommendation to how to obtain the medication from the most cost efficient Participating Provider. The program includes 1-on-1 coaching based on Plan provisions, support and education to improve adherence and avoid complications.

This is a voluntary service. There are no reductions of benefits or penalties if the Covered Person and family choose not to participate or comply with recommendations or suggestion provided by case managers.

AMENDMENT NO. 8 TO THE SHEET METAL WORKERS
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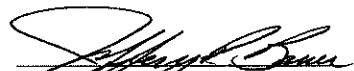
Effective June 1, 2020, the Trustees of the Sheet Metal Workers Local 268 Welfare Plan hereby amend the Plan Document and Summary Plan Description ("SPD") in the manner set forth below.


The table in Section C.2. Schedule of Medical Benefits, is amended by deleting the column entitled Tier 2 benefits.

All other references to "Tier 2" benefits throughout the document are also deleted.

IN WITNESS WHEREOF, the Plan is amended as of the date set forth above.


UNION/EMPLOYEE TRUSTEES


Jeff Bauer 07/07/2020
Date

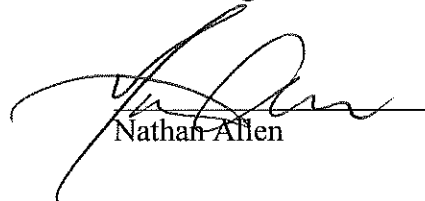

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