

**SHEET METAL WORKERS LOCAL 104 HEALTH CARE PLAN
(As revised January 2021)**

Amendment 25

Pursuant to the authority set forth in Article VII of the Agreement and Declaration of Trust, the Trustees hereby amend the Sheet Metal Workers Local 104 Health Care Plan as follows:

1. **Effective September 16, 2025, the “Appeals Procedures” subsection of the “Claims and Appeals Procedures” is revised to read as follows:**

APPEALS PROCEDURES

If you do not receive benefits from the Plan that you feel you are entitled to, you should contact the Trust Fund Office to discuss your claim.

If your claim is wholly or partially denied, you will receive a written notice of denial that will contain the following information:

1. The specific reason for the denial with specific reference to pertinent Plan provisions on which the denial is based;
2. A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material is necessary;
3. Appropriate information as to the steps to be taken if you wish to submit the claim for review;
4. The specific rule, guideline, protocol, or other similar criterion, if any, relied upon in making the determination;
5. An explanation of the scientific or clinical judgment for the determination if the adverse benefit determination was based on medical necessity or other similar exclusion or limitation.

Emergency Care Claims

The determination as to whether a claim involves Emergency Care is determined by the attending provider and the Plan defers to such determination. In the case of an Emergency Care claim, the Administrative Office will notify you of the Plan’s benefit determination (whether adverse or not) as soon as possible, taking into account the seriousness of your medical condition, but not later than 24 hours after receipt of the claim by the Plan, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Administrative Office will notify you within 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. You will be given a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Administrative Office will notify you of the Plan’s benefit determination as soon as possible, but

in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified information; or (2) the end of the period given to you to provide the specified additional information.

Pre-Service Claims

The benefit determination, whether adverse or not, will be given within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the claim is filed, and unless special circumstances beyond the control of the Plan require an extension of time for processing the claim. If such extension is required, you will be sent written notice before the expiration of the initial 15 day period, stating the special circumstances requiring the extension and the date by which a decision on the claim can be expected. If such extension is necessary due to a failure by you to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be given at least 45 days from the receipt of the notice within which to provide the specified information.

Post-Service Claims

The notice of denial will be given within 30 days after the claim is filed, unless special circumstances beyond the control of the Plan require an extension of time for processing the claim. If such extension is required, you will be sent written notice before the expiration of the initial 30 day period, stating the special circumstances requiring the extension and the date by which a decision on the claim can be expected. If such extension is necessary due to a failure by you to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be given at least 45 days from the receipt of the notice within which to provide the specified information.

Concurrent Care Decision

If you are receiving an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of such treatment will be deemed an adverse benefit determination. Notice of such determination will be sent at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

Any request by you to extend the course of treatment beyond the period of time or number of treatments involving an Emergency Care claim will be decided as soon as possible, taking into account the seriousness of your medical condition, and the Administrative Office will notify you of the benefit determination, whether adverse or not, within 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Benefit Determination on Review
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If your claim is denied, you have a right to appeal by submitting a written application to the Board of Trustees within 180 days. If the benefits involved are provided by an insurance company, insurance service, Health Maintenance Organization (HMO), Pharmacy Benefit Manager (PBM) or other similar organization, the Trustees may permit that organization to conduct the review and make the decision. You or your representative may review the Plan documents and submit written

comments to the Trust Fund Office, but shall have no right to appear personally before the reviewing group unless that group concludes that such an appearance would be of value in enabling it to perform its obligations hereunder. Appeals will be reviewed and decided on by the Board of Trustees or the Appeals Committee. However, the Board of Trustees or Appeals Committee may delegate this power to an authorized designee or other committee of Trustees. The Board of Trustees, Appeals Committee, and any other duly authorized designee shall have the authority to determine eligibility for benefits under the Plan and to construe the terms of the Plan.

In the case of a claim involving Emergency Care, a request for an expedited appeal for an adverse benefit determination may be submitted orally or in writing by you or your duly authorized representative, and all necessary information, including the Plan's benefit determination will be transmitted to you by telephone, facsimile, or other available similarly expeditious method.

You or your duly authorized representative will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. Relevant information includes identification of any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit decision. You will also be provided any statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination. The Trustees will not afford any deference to the initial benefit determination. If the adverse benefit determination is based in whole or in part on a medical judgment, the Board of Trustees, Appeals Committee, or other duly authorized designee will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. Such consultant will be different from any individual consulted in connection with the initial determination or the subordinate of any such person.

Emergency Care Claims

You will be notified of the Plan's benefit determination on review as soon as possible, taking into account the seriousness of your medical condition, but not later than 72 hours after receipt of your request.

Pre-Service Claims

You will be notified of the Plan's benefit determination on review within a reasonable time, but not later than 30 days after receipt by the Plan of your request for review of an adverse benefit determination.

Post-Service Claims

Upon receipt of a petition for review, the Trustees, Appeals Committee, or other duly authorized designee appointed by the Trustees and authorized to act on such petitions, will proceed to review the administrative file, including the petition for review and its contents. All comments, documents, records and other information submitted by you relating to the claim will be taken into account without regard to whether such information was submitted or considered in the initial benefit determination. A decision by the Trustees will be made no later than the next succeeding

regular Trustees' meeting following the request for review, except that a request for review received within thirty (30) days preceding the date of such meeting. In such case, a benefit determination may be made no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination will be made no later than the third meeting following the receipt of the petition for review. Notification of the extension will be sent to you prior to the commencement of the extension describing the special circumstances and the date by which the benefit determination will be made. You will be notified of the decision of the Trustees, Appeals Committee, or other duly authorized designee in writing within five (5) days after the benefit determination is made.

Any notice of adverse benefit determination will be in writing and include the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific Plan provisions on which the benefit determination is based;
3. A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relevant to Claimant's claim;
4. A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures;
5. A statement of your right to bring an action under ERISA Section 502(a);
6. The specific rule, guideline, protocol, or other similar criterion, if any, relied upon in making the determination; and
7. An explanation of the scientific or clinical judgment for the determination if the denial was based on medical necessity or other similar exclusion or limit.

In the event that you desire additional time to present evidence in support of your petition for review, you may request such additional time in writing. The Trustees will grant your written request for additional time necessary to perfect a petition for review, provided the written request is received before the Trustees issue their decision. Requests for additional time and requests to submit additional information received after the Trustees' decision has been rendered will be denied, unless the Trustees, in their sole discretion, determine that the information is material to the petition and could not have been provided earlier.

If the benefits involved are provided by an insurance company, insurance service, HMO, or other similar organization, that organization may be entitled to conduct the review and make the decision. Disputes concerning benefits provided by an HMO generally must be resolved using the appeal procedure established by that organization. See the applicable HMO brochure for details of the organization's claims and appeals procedures. As part of the review procedure, you or your authorized representative may review pertinent documents and submit issues and comments in writing.

The Trustees, Appeals Committee, or other duly authorized designee have full discretionary authority to determine eligibility for benefits, interpret all plan provision, and to make all factual determinations concerning any claim or right asserted under or against the Plan or Trust Fund. The Trustees, the Appeals Committee, or other duly authorized designee have absolute discretion to grant an appeal if, based on the specific facts and circumstances, it is in the best financial interest of the Plan.

The decision of the Trustees, Appeals Committee, or other duly authorized designee shall be final. No lawsuit may be filed without first exhausting the above appeals procedure. In any such lawsuit, the determination made by the Trustees, Appeals Committee, or other duly authorized designee is subject to judicial review for only abuse of discretion. No legal action may be commenced or maintained against the Plan more than two (2) years after a claim has been denied.

This Amendment 25 was adopted by the Board of Trustees on September 16, 2025. The Chairman and Co-Chairman were authorized by the Board of Trustees to execute this Amendment on their behalf. This Amendment 25 may be executed in counterparts, each of which shall be deemed to be an original, but all of which together shall constitute one and the same Amendment 25.

Fick Werner

Chairman

Date: 9/19/2025 | 2:04 PM EDT

Sean O'Donoghue

Co-Chairman

Date: 9/17/2025 | 11:51 AM PDT