SOUTH CENTRAL MINNESOTA ELECTRICAL WORKERS' FAMILY HEALTH PLAN

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

AMENDED AND RESTATED EFFECTIVE MAY 1, 2023

SOUTH CENTRAL MINNESOTA ELECTRICAL WORKERS'
FAMILY HEALTH PLAN

To All Participants:

We are pleased to furnish you with this new Plan Document and Summary Plan Description ("booklet" or "SPD"). As Trustees of your health care plan, we want you to have all the information about your Plan including the eligibility rules, a description of the type and amount of benefits available, as well as any limitations and exclusions which may cause you to lose benefits. This SPD also provides you with instructions for filing a claim and tells you all of the requirements brought about by the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

The SPD can only be helpful to you if you use it. We urge you to read the booklet now and keep it available for future reference whenever you or your family needs information about your health care benefits.

We administer your Plan with the help of a Plan Administrator, administrative office staff, professional benefits consultants, legal counsel, and a certified public accounting firm. As Trustees of your Plan, we will continue to manage the Plan assets in a financially responsible manner and to keep the level of benefits in line with medical care costs as permitted by income and reserves.

We hope that you will find this explanation of your Plan helpful. If you have any questions at any time regarding your Plan, please contact the Administrative Manager, Wilson-McShane Corporation, at (952) 851-5949 or (800) 535-6373.

Sincerely,

The Board of Trustees

GRANDFATHERED STATUS
UNDER THE
PATIENT PROTECTION AND AFFORDABLE CARE ACT

The Trustees believe this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act" or "ACA"). 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 your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive 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 key 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 Administrative Manager at (800) 535-6372 or (952) 854-0795. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

COMPLIANCE WITH THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

This Plan complies with the Mental Health Parity and Addiction Equity Act (the "MHPAEA").

Questions regarding the MHPAEA can be directed to the Administrative Manager at (800) 535-6372 or (952) 854-0795. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity.

HOW TO USE THIS BOOKLET

This booklet has been revised to provide you with a thorough explanation of the benefits available to you and your Eligible Dependents under this Plan. A summary is provided in the box at the beginning of each Section. Those summaries provide you with an overview of the subjects discussed in each Section and will be useful in answering many questions you and your Eligible Dependents have about the Plan. Of course, more details are provided after the summary of each Section. You should always review the entire Section or Sections when determining what benefits you or your Eligible Dependents may be entitled to receive.

Throughout this booklet, you will see that certain terms are capitalized. If a term is capitalized anywhere but the beginning of the sentence, this typically means that the term has a specific definition. Section 4 of the Plan contains these definitions.

If you have any questions about the Plan, you should contact the Administrative Manager.

Special Features of the Plan

The Trustees would like to make you aware of special programs and benefits that are available to you and your Eligible Dependents who are covered by this Plan. The specific description of each of these programs and benefits is contained elsewhere in this booklet. Please refer to the Sections or Subsections provided below for that additional information.

Employee Assistance Program

(For assistance with alcoholism, chemical dependency, mental and nervous disorders and other life issues)

The Plan provides an Employee Assistance Program through TEAM's Employee Assistance Program. TEAM will confidentially assess issues you are facing, provide counseling to you and your family to resolve those issues, and even refer you to others who can help you with those issues. A partial list of issues TEAM will address is contained in the Subsection entitled "Your Employee Assistance Program Provided Through TEAM" in Section 13 of this booklet ("Mental Health and Chemical Dependency Benefit").

TEAM's services are covered under the Plan [at no charge] and are available to you twenty-four (24) hours a day, seven (7) days a week. **Of course, you have to take the first step and call TEAM at (651) 642-0182 or (800) 634-7710.** The Trustees urge you to do that before a small problem becomes a big one.

Wellness Benefits

Your health, and that of your family, is your most valuable asset. The Trustees recognize that when you and your Eligible Dependents are healthy, this Plan is not required to pay for expensive medical treatment. Of course, if you do not incur claims, the cost to you is also reduced.

In order to promote your good health, the Trustees have approved the Plan's payment of wellness benefits. These include regular physical examinations for you and your Spouse, well child care for your newborn and pre-school age children, and a regular immunization schedule for your children. See the descriptions of the "Routine Physical Examination" benefit and "Well Child Care and Immunizations" on the Schedule of Benefits and in Section 8 of this booklet ("Covered Medical

Expenses") for details. The Trustees encourage you to use these benefits to ensure that you and your loved ones remain happy and healthy.

Preferred Provider Network

The Plan has entered into a preferred provider arrangement with United Healthcare. United Healthcare provides a network of health care providers and health care facilities that have agreed to provide quality medical services to you and your Eligible Dependents. The network offers both you and the Plan the opportunity to better manage and control health care cost.

There are advantages for you and your Eligible Dependents if you choose to use the network. The network will usually provide discounts from the charges of a health care provider or a health care facility. The providers in the network have agreed to a different schedule of charges for patients who use the network. If the cost of care for covered services is lower (which it usually is) in the network, both you and the Plan should save money.

Please remember, however, that you have the choice of whether to obtain medical services in or out of the network. The Plan will still make payment to providers that are not part of the United Healthcare Network Service Area ("non-participating providers"). In general, if you use a non-participating provider, you will pay more out-of-pocket costs. However, effective May 1, 2022, the Plan *will* cover (a) claims for Emergency Services provided by an out-of-network provider and/or at a non-Participating Health Care Facility; (b) claims for certain non-Emergency Services furnished to you by an out-of-network provider at a Participating Health Care Facility; and (c) claims for out-of-network Air Ambulance Services as though these items and services were provided by in-network providers. Note that claims of these types are still subject to the Plan's rules, regulations, limitations, and exclusions, including standard cost sharing requirements and coordination of benefits rules. The exact costs payable by you and the Plan for such claims will be determined in accordance with the rules and regulations established and in effect at the time the services are provided pursuant to the Consolidated Appropriations Act, 2021. Network discounts do not apply in any way to charges for services that are not covered by the Plan. So, if you go to a network provider to receive a service that is not covered by the Plan, the amount the provider may charge you will not reflect the network discount that would have applied if the service was covered by this Plan.

Make sure you show your network membership card each time you visit a health care provider, Hospital, or other health care facility. By doing so, you can assure yourself that you are receiving any discounts to which you are entitled.

IMPORTANT NOTICES

Interpretation of this Booklet

Only the full Board of Trustees ("Board") and, in certain situations, its delegates (including the Plan Administrator) have authority to determine eligibility for the benefits described in this booklet and to interpret the terms of this booklet. The Board's interpretation will be final and binding on all individuals dealing with the Plan or claiming a benefit from the Plan. If a decision of the Board is challenged in court, it is the intention of the parties that the decision is to be upheld unless it is determined to be arbitrary or capricious. No Employer, Union, nor any representative of any Employer or Union, acting in that capacity, is authorized to interpret the Plan, nor can any such individual act as agent of the Board. If you would like any information regarding this Plan, the information must be communicated to you in writing signed on behalf of the full Board of Trustees, either by the Trustees or, if authorized by the Board, by the Plan Administrator.

Trustee Authority

The Board has full authority to determine eligibility for Plan benefits; to construe the terms of this Plan Document and Summary Plan Description; to increase, reduce, or eliminate benefits; and to change the eligibility rules or other provisions of the Plan at any time. This authority extends to all aspects of the Plan, including, but not limited to, any Emergency medical program providing reduced coverage at a reduced self-payment rate. However, the Trustees intend that the Plan terms, including those relating to coverage and benefits, are legally enforceable and that the Plan is maintained for the exclusive benefit of Eligible Individuals. The right to change or eliminate any and all aspects of benefits provided for Retirees and their Dependents also is a right specifically reserved to the Trustees. Therefore, this booklet may not accurately describe benefits to which you may be entitled. The Plan will send notice of any changes to each known Eligible Individual at the last address provided by the Eligible Individual to the Plan within the time required by applicable regulations. However, changes may take effect before you are notified of a change. Before incurring any non-Emergency expense, you should contact the Plan Administrator to confirm your current entitlement to coverage.

IF YOU MOVE, NOTIFY THE PLAN ADMINISTRATOR IMMEDIATELY!

Most information about your Plan will be sent to you by mail. In order for you to promptly receive this information, YOU MUST PROVIDE THE PLAN ADMINISTRATOR WITH YOUR CURRENT ADDRESS FOR THE PLAN'S RECORDS.

THE BOARD OF TRUSTEES

Union Trustees:

Steve Cardell
IBEW Local Union 343
9 80th Street SE
Rochester, MN 55904

Dean Hogstad
IBEW Local Union 343
9 80th Street SE
Rochester, MN 55904

Steven Olson
IBEW Local Union 343
9 80th Street SE
Rochester, MN 55904

Sean Sannes
IBEW Local Union 343
9 80th Street SE
Rochester, MN 55904

Management Trustees:

Kristin Causby
Minneapolis Chapter NECA
600 Highway 169 South, Suite 640
St. Louis Park, MN 55426

Mark Draper
River City Electric Company
PO Box 164
Mankato, MN 56002

Don Hameister
HG Electric LLC
2755 Brookwood Court SE
Eyota, MN 55934

Jason Tentis
Egan Company
4475 Highway 14 W
Rochester, MN 55901

Administrative Manager:

Wilson-McShane Corporation
1330 Conway Street, Suite 130
St. Paul, MN 55106

Plan Accountant:

Larry Wood
Legacy Professionals
6800 France Avenue South, Suite 550
Edina, MN 55435

Plan Consultant:

Hans Kraabel
United Actuarial Services, Inc.
11590 N. Meridian Street, Suite 610
Carmel, IN 46032

Plan Counsel:

Cindy L. Davis, Attorney
Shumaker, Loop & Kendrick, LLP
8400 Normandale Lake Blvd., Suite 920
Bloomington, MN 55437

Pharmacy Benefit Manager:

CVS Caremark
1- 866-818-6911

TABLE OF CONTENTS

SECTION 1 DEFINITIONS

SUMMARY

This booklet contains many words and phrases that describe the benefits you may receive. Many words and phrases have been given specific meanings and are defined in this Section. For example, "Dependent" is defined to include many people in addition to your Spouse and natural children.

You should always check the definition of defined words and phrases so that you understand how they are used in this booklet.

Wherever used in this Summary Plan Description, the following terms have the meanings described below.

1.1. ACTIVELY AT WORK AND EMPLOYED FULL-TIME

The regular practice of a job or trade in the service of the Employer. Employed Full-Time means that the Employee is Actively At Work at least one hundred (100) hours per month. If the Employee was Actively At Work on the last normal workday, the Employee will be deemed Actively At Work on each normal paid vacation or non-work day on which the Employee is not disabled.

1.2. AIR AMBULANCE SERVICES

Medical transport for patients by a rotary wing air ambulance or fixed wing air ambulance.

1.3. AMBULATORY SURGICAL CENTER

A freestanding ambulatory surgical center, public or private, which meets the following criteria:

A. The facility provides organized medical staff of Physicians;

B. Its facilities are permanent and are equipped and operated primarily for the purpose of performing surgical procedures;

C. The facility provides twenty-four (24) hour Physician and registered nursing service; and

D. The facility has been reviewed and approved by the state board of health to provide this treatment or these services.

1.4. BENEFICIARY

An individual or entity named on a form and in a manner provided by the Plan, to receive benefits for loss of life.

1.5. BENEFIT PERIOD

The period of time during which Covered Expenses are incurred for which benefits may be paid.

1.6. BENEFIT PROGRAM

The specific Schedule of Benefits determined by the Trustees as available under the Plan.

1.7. BODY MASS INDEX ("BMI")

A number which is a measure of weight for height and which can be calculated by a Physician to determine weight status.

1.8. CALENDAR YEAR

12-month period starting on January 1 of any year and ending on December 31 of that same year.

1.9. CLINICAL HISTORY

Any record of an event or events indicating that an individual was under the care or treatment of a Physician.

1.10. CLOSE RELATIVE

Close Relative means the Employee, the Employee's Spouse, or a child, brother, sister, or parent of the Employee or the Employee's Spouse.

1.11. COINSURANCE

The portion of a Covered Expense in excess of the Deductible that you must pay. Copayments are not applied toward the amount of Coinsurance that you must pay.

1.12. COLLECTIVE BARGAINING AGREEMENT

That Agreement in force and effect between the Union and a Contributing Employer, which require the Employer to make Contributions to the Plan on behalf of its Employees for work performed within the jurisdiction of the Union, including all modifications of amendments to, and memoranda of understanding in addition to such Collective Bargaining Agreement.

1.13. CONTRIBUTIONS

Payments made to the Plan by Contributing Employers pursuant to a Collective Bargaining Agreement or Participation Agreement on behalf of their Employees, and Employee payments to the Plan as required by such agreements; Self-Contributions; and reciprocity contributions.

1.14. CONVENIENCE CARE CLINICS

Convenience Care Clinics provide services and treatment for basic illnesses such as ear aches, skin infections, strep throat, pink eye, and similar problems.

1.15. COPAYMENT

A fixed dollar amount that you must pay for certain Covered Expenses. Copayments are not applied toward your Deductible or your Coinsurance.

1.16. COVERED CHARGES OR EXPENSES; COVERED MEDICAL EXPENSES

The Reasonable and Customary Charges incurred by an Eligible Individual upon the recommendation and approval of the attending Physician for services and supplies required for treatment of the individual as a result of a non-occupational accidental bodily Injury or Sickness and for which Plan benefits are payable, subject to the Maximum Benefits specified on the Schedule of Benefits.

1.17. COVERED INDIVIDUAL

An Eligible Individual who is: (i) Covered Under The Plan; and (ii) receiving benefits from the Plan during the applicable time period.

1.18. COVERED OR COVERED UNDER THE PLAN

A term used to indicate that an individual is eligible to receive the Plan benefits which apply to his or her status as an Employee, a Retiree, or a Dependent.

1.19. COVERED EMPLOYMENT

Work performed within the jurisdiction of the Union by an Employee for an Employer for which the Employer is required to make Contributions to the Trust Fund on the Employee's behalf. Work performed within the jurisdiction of another IBEW local union for which Contributions may be transferred under a reciprocal agreement.

1.20. DEDUCTIBLE

The amount that you must pay each Calendar Year for Covered Expenses before the Plan will begin to pay for Covered Expenses (subject to all other Plan terms and conditions). Copayments are not applied toward the Deductible.

1.21. DEPENDENT; ELIGIBLE DEPENDENT

An individual who is:

A. An Employee's or Retiree's Spouse under a legally recognized existing marriage, provided he or she is not legally separated from the Employee or Retiree. "Spouse" means an individual who is legally recognized as married to an Employee or Retiree under the laws of the state in which the marriage was established. For this purpose, a legal civil union is considered a legal marriage. A certified copy of an Employee or Retiree's marriage certificate or other documentation substantiating legal recognition of a marriage may be required to be on file at the Fund Office before claims for your Spouse (and, if otherwise eligible, your Spouse's children) can be processed.

B. Your (Employee's or Retiree's) child:

   1. Who is less than twenty-six (26) years old; or

   2. Who is twenty-six (26) years old or older and physically or mentally-disabled. The child must: (i) have become disabled while a Dependent as described above (less than twenty-six (26) years old); (ii) be incapable of self-sustaining employment; and (iii) must be dependent on you for the major portion of his or her support. When the first claim is filed for the child, you must furnish proof that your child became

disabled while a Dependent. You must furnish the proof at your own expense except that, if the Trustees require a physical examination, the Plan will pay for it. If the Trustees request proof of the child's disability in the future, you must furnish the proof or the child's coverage will terminate; or

3. Who is required to be Covered Under the Plan according to the terms of a court decree called a Qualified Medical Child Support Order ("QMCSO") requiring you to provide health coverage for the child. A QMCSO may also be available through a special administrative process adopted by the state in which you reside. A copy of the QMCSO will be required by the Plan before claims for the child will be considered for payment.

   A QMCSO is a special order from the court that requires a health care plan to provide coverage to children of divorced or separated parents, or children born out of wedlock. There are several specific requirements that must be able to help you obtain an order that satisfies these requirements. Your divorce or family attorney should be able to help you obtain an order that satisfies these requirements.

C. For the purposes of the definition of Dependent, a "child" means any of the following:

1. Your biological child.

2. Any child legally adopted by you or placed for adoption with you. "Placed for adoption" means the assumption and retention by you of a legal obligation to partially or totally support a child in anticipation of adopting that child. The "placed for adoption" status terminates upon the termination of that legal obligation.

3. Any stepchild of yours, meaning any child of your current Spouse from whom you are not legally separated or divorced:

   a. Who was born to such Spouse;

   b. Who was legally adopted by such Spouse;

   c. Who has been placed for adoption with such Spouse; or

   d. Who is a foster child placed with such Spouse by an authorized placement agency or a court.

4. Any foster child placed with you by an authorized placement agency or a court.

5. Your grandchild, provided that a parent of that grandchild is: (i) your Eligible Dependent child under this Plan; (ii) under age nineteen (19) or, if the parent is a full-time student, under age twenty-six (26); and (iii) unmarried, and provided also that you, the parent of the grandchild, and the grandchild all reside in the same household.

   The Eligible Dependent child (who is the parent of your grandchild) is a full-time student if he or she is: (i) registered as a full-time student in an accredited secondary school, college, university, vocational, or technical school or institute; (ii) has been continuously enrolled therein since the academic year that began

immediately before he or she reached age nineteen (19); and (iii) is dependent on you for the major portion of his or her support.

D. If your child works for a Contributing Employer and is eligible for benefits under this Plan as an Employee, the child will not be considered a Dependent under this Plan.

1.22. ELIGIBLE EMPLOYEE

Any Employee who has met the eligibility requirements established by the Trustees for being Covered Under The Plan.

1.23. ELIGIBLE INDIVIDUAL

An individual who is an Employee, Retiree, or Dependent and who has met the eligibility requirements established by the Trustees for being Covered Under The Plan.

1.24. EMERGENCY

A medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

A. Placing the health of the person (or in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

B. Serious impairment to bodily function; or

C. Serious dysfunction of any bodily organ or part.

1.25. EMERGENCY SERVICES

A. An appropriate medical screening that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department and ancillary services routinely available to the emergency department to evaluate such Emergency medical condition; and

B. Such further medical examination and treatment to stabilize the patient as are within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department (regardless of the department of the Hospital in which such further examination or treatment is furnished).

1.26. EMPLOYEE

An individual who is performing work for an Employer as an employee and on whose behalf Contributions are being made to the Plan pursuant to a Collective Bargaining Agreement or a Participation Agreement, unless the context in which the term is used indicates a different meaning.

1.27. EMPLOYER; CONTRIBUTING EMPLOYER

Any individual, firm, association, partnership or corporation which is required, under the terms of a Collective Bargaining Agreement with the Union to make Contributions to the Plan on behalf of its Employees covered by the Agreement; and any association or other Employer which is required under the terms of a Participation Agreement with the Trustees to make Contributions to the Plan on behalf of its Employees who are not covered by a Collective Bargaining Agreement.

1.28. EMPLOYER'S ASSOCIATION

The Minneapolis Chapter of the National Electrical Contractors Association, Inc. and the Limited Energy Association, which are parties to a bargaining agreement requiring Contributions to the Trust Fund.

1.29. ESSENTIAL HEALTH BENEFITS

Any Covered Expenses that constitute Essential Health Benefits as that term is defined under the Patient Protection and Affordable Care Act or related regulations, rules, or guidance. As defined under the Affordable Care Act, Essential Health Benefits means at a minimum, any medical services that are ambulatory patient services; Emergency Services hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

In no situation will Essential Health Benefits mean any medical services that are not Essential Health Benefits under the Affordable Care Act or any medical services the cost of which is not a Covered Expense under this Plan.

1.30. EVIDENCE OF ELIGIBILITY

A standard form that requests pertinent medical information concerning the medical history of the individual(s) eligible for coverage subject to Trustee approval.

1.31. EXPERIMENTAL OR INVESTIGATIVE

The use of any treatment (which includes use of any treatment, procedures, facility, drug, equipment, device, or supply) is considered to be Experimental or Investigative if the use is not yet generally recognized as accepted medical practice, or if the use requires federal or other governmental agency approval and the approval has not been granted at the time the service or supply is provided, or if the use is not supported by Reliable Evidence (as defined below) which shows that, as applied to a particular condition, it:

A. Is generally recognized as a safe and effective treatment of the condition by those practicing the appropriate medical specialty; and

B. Has a definite positive effect on health outcomes; and

C. Over time leads to improvement in health outcomes under standard conditions of medical practice outside clinical investigatory settings (i.e., the beneficial effects outweigh the harmful effects); and

"Reliable Evidence" includes only:

1. Published reports and articles in authoritative medical and scientific literature;

2. The written investigational or research protocols and/or written informed consent used by the treating facility or of another facility which is studying the same service, supply, or procedure; and

3. Compilations, conclusions, and other information which is available and may be drawn or inferred from (1) or (2), above.

D. Consideration may be given to whether:

1. The treatment cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the treatment is furnished; or

2. Reliable Evidence shows that the treatment is the subject of ongoing Phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with standard means of treatment or diagnosis; or

3. Reliable Evidence shows that consensus among experts regarding the treatment is that further studies or clinical trials are necessary to determine tolerated doses, its toxicity, its safety, its efficacy, or its efficacy as compared with standard means of treatment or diagnosis; or

4. The mortality rate of the treatment; the cure rate and the survival rate for patients using the treatment for the particular Injury, Sickness or condition as compared with rates for similarly situated patients using no treatment or using existing treatments which are generally accepted by the Food and Drug Administration; and the number of patients who have received the treatment for the same Injury, Sickness or condition.

Any medical and surgical complications resulting from the excluded treatments are also excluded.

The final determination of whether the use of a treatment is Experimental or Investigative will rest solely with the Trustees.

1.32. FULL-TIME EMPLOYEE

Employees who work thirty (30) or more hours per week and who are not seasonal employees (seasonal employees are those employed ninety (90) days or less on a casual temporary basis and in a non-permanent class).

1.33. HOSPITAL

An institution which is engaged primarily in providing medical care and treatment to sick and injured individuals on an Inpatient basis at the patients' expense and which fully meets all of the requirements set forth below:

A. It is a Hospital, a psychiatric Hospital, or a tuberculosis Hospital, as those terms are defined by Medicare, which is qualified to participate in Medicare and to receive Medicare payments; or

B. It is a Hospital accredited by the Joint Commission on Accreditation of Health Care Organizations; or

C. With respect to treatment of mental or nervous disorders, it is a community mental health center or mental health clinic established for the purpose of providing consultation, diagnosis and treatment in connection with a mental Sickness or functional nervous disorder and is approved or licensed by the commissioner of public welfare or other authorized state agency; or

D. With respect to an Emotionally Handicapped Child, it is a licensed residential treatment facility established for the purpose of treating emotionally handicapped children and approved or licensed by the state. "Emotionally Handicapped Child" is a child under nineteen (19) years of age who, in the judgment of a professional, social worker, psychiatrist, or psychologist, is exhibiting those symptoms or behavior patterns that are determined to be of such a nature that the child needs the care and treatment provided at such facility; or

E. With respect to the treatment of alcoholism, chemical dependency or drug addiction, it is confinement in a residential primary treatment program licensed by the state; or

F. It is an institution which meets all of the following requirements:

1. It provides diagnostic and therapeutic facilities for the medical and surgical diagnosis, treatment and care of injured and sick persons under the supervision of a staff of Physicians licensed to practice medicine;

2. It provides on the premises 24-hour-a-day nursing services by or under the supervision of registered graduate nurses (RN);

3. It is operated continuously with organized facilities for operative surgery on the premises; and

4. It is **not** an institution which is primarily a clinic or, other than incidentally, a place for rest, for the aged, or a nursing or convalescent home or similar establishment.

1.34. INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT

A health care facility that is geographically separate and distinct and licensed separately from a Hospital under applicable state law and provides any Emergency Services.

1.35. INJURY

Bodily Injury resulting from an accident. The Injury must directly result from the accident; must be independent of all other causes; must result in a covered loss; must not be caused or contributed to by Sickness.

1.36. INPATIENT

An individual who, while Hospital confined, is assigned to a bed in a department of the Hospital other than the Outpatient department and is charged for a room by the Hospital.

1.37. INTENSIVE CARE UNIT

A special area of a Hospital, exclusively reserved for critically ill patients requiring constant observation, which in its normal course of operation provides:

A. Personal care by specialized registered professional nurses and other nursing care on a twenty-four (24) hour per day basis;

B. Special equipment and supplies which are immediately available on a stand-by basis;

C. Care required but not rendered in the general surgical or medical nursing units of the Hospital. The term "Intensive Care Unit" will also include an area of the hospital designated and operated exclusively as a coronary care unit or as a cardiac care unit; and

D. Care not included is any Hospital facility maintained for the purpose of providing normal post-operative recovery treatment or service.

1.38. MEDICALLY NECESSARY

Only those services, treatments or supplies provided by a Hospital, a Physician or other qualified provider of medical services or supplies that are required, in the judgment of the Trustees and based on the opinion of a qualified medical professional, to identify or treat an Eligible Individual's Injury or Sickness and which:

A. Are consistent with the symptoms or diagnosis and treatment of the Eligible Individual's condition, disease, ailment, Sickness or Injury;

B. Are appropriate according to the standards of good medical practice;

C. Are not solely for the convenience of the Eligible Individual, Physician or Hospital;

D. Are the most appropriate and can be safely provided to the Eligible Individual;

E. Are not deemed to be Experimental or Investigative; and

F. Are not furnished in connection with medical or other research.

1.39. MEDICARE

The Health Insurance for the Aged Program under Title XVIII of the Social Security Act as such Act was amended by the Social Security Amendments of 1965 (Public Law 89-97) and as the program currently exists and as it may later be amended.

1.40. MILITARY SERVICE

The performance of duty on a voluntary or involuntary basis in the Uniformed Services, including active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, state active duty in response to a national emergency declared by the President under the National Emergencies Act, state active duty in response to a major disaster declared by the President under Section 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty; a period for which a system member of the National Urban Search and Rescue Response System is absent from a position of employment due to an appointment into federal service under Section 327 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act; attendance at the United States Military Academy, the United States Naval Academy, the United States Air Force Academy, or the United States Coast Guard Academy; a period for which a participant in the National Disaster Medical System is activated to provide assistance in response to a public health emergency or to be present for a short period of time when there is a risk of a public health emergency, or when they are participating in authorized training; and a period for which a person who is a member of the Uniformed Services is absent from employment for the purpose of performing funeral honors duty. All periods of a Participant's Military Service, however, that exceed five years (whether as a single period of Military Service or cumulative periods of Military Service) are not taken into account as "Military Service" under this Plan, except when the Military Service exceeds five years due to certain requirements, orders, or other exceptions as provided by USERRA. For more information about these exceptions, contact the Fund Office.

1.41. NON-ESSENTIAL HEALTH BENEFIT

Any Covered Expense that is not an Essential Health Benefit.

1.42. OUTPATIENT

An Employee who receives Hospital services and treatment but not as an Inpatient. The patient is not charged for room and board.

1.43. PARTICIPATING HEALTH CARE FACILITY

Any health care facility that has a contractual relationship directly or indirectly with the Plan setting forth the terms and conditions on which a relevant item or service is provided to an Eligible Individual Covered Under the Plan.

1.44. PARTICIPATION AGREEMENT

A written agreement between the Trustees and an Employer whereby the Trustees approve the participation by Employees of the Employer in the Plan and which shows the commitment of the Employer to be bound by the Trust Agreement as if an original party to it, and whereby the Employer agrees to make and the Trustees agree to accept Contributions to the Plan on behalf of the Employer's Employees who are not members of the bargaining group. The Trustees, in approving and executing any Participation Agreement, will by appropriate action determine the rate of Contribution to be paid to the Plan by the Employer on behalf of its Employees.

1.45. PHYSICIAN

An individual licensed to practice medicine (healing arts) by the governmental authority having jurisdiction over such licensure. The Physician must be practicing within the scope of his/her license for the service or treatment given. This definition does not include a Physician who is the Employee or Close Relative.

1.46. PLAN, PLAN OF BENEFITS

The Benefit Program provided by the South Central Minnesota Electrical Workers' Family Health Plan.

1.47. PLAN YEAR

12-month period starting on July 1 of any given year and ending on immediately succeeding June 30.

1.48. REASONABLE AND CUSTOMARY, REASONABLE AND CUSTOMARY CHARGE

An amount determined by comparing a particular charge with the charges made for similar services and supplies in the locality concerned to individuals of similar age, sex, circumstances and medical condition. The result of this comparison determines the amount that is the maximum allowable charge to be considered a Covered Expense under this Plan. A Reasonable and Customary Charge will not exceed charges actually incurred.

1.49. RETIREE, RETIRED EMPLOYEE

An individual who was an Eligible Employee under this Plan on the day preceding the date of his or her retirement and who is now retired either under the retirement provisions of a pension plan negotiated or sponsored by the Union or under the provisions of the Social Security Program.

1.50. SCHEDULE OF BENEFITS, SCHEDULE

The Section of this Plan which outlines Plan benefits.

1.51. SELF-CONTRIBUTIONS

Payments made to the Plan by Employees, Retirees, and Dependents on their own behalf for the purpose of maintaining coverage under the Plan, for defraying the additional cost of an elected health care organization, and for Continuation Coverage under COBRA.

1.52. SICKNESS

A disorder or disease of the body or mind. Sickness for the purposes of this definition also includes pregnancy and childbirth.

1.53. TELEMEDICINE SERVICES

Telemedicine services provide live, face-to-face visits through a smartphone, tablet, or computer, and may be used to treat common medical issues such as cold and flu, allergies, skin and eye issues, sore throat, and similar problems.

1.54. THIRD-PARTY

Any individual, entity, federal, state or local government agency, or insurer (including, but not limited to, liability, medical expense, wage loss, workers' compensation, premises liability, no-fault, uninsured or underinsured motorist insurers) who is or may be in any way legally obligated to reimburse, compensate or pay for an Eligible Individual's loss, damages, injuries or claims relating in any way to the Injury, occurrence, condition or circumstance giving rise to the Plan's provision of medical or disability benefits.

1.55. TOTAL DISABILITY, TOTALLY DISABLED

A. With respect to an Eligible Employee, the complete inability of the Eligible Employee, as a result of a non-occupational accidental bodily Injury or Sickness, to engage in his or her occupation or employment for which he or she is or becomes qualified for by reason of education, training or experience.

B. With respect to a Dependent or Retiree, the complete inability to perform the normal activities of an individual of like age and sex in good health because of a non-occupational accidental bodily Injury or Sickness.

You must be under the care of a Physician during the entire period of your Total Disability. Your Physician must provide written certification to the Plan Administrator of your disabled status. Finally, the Trustees reserve the right to request evidence of continuing Total Disability and may require you to have a physical examination by a Physician chosen and paid for by the Plan.

1.56. TRUST, TRUST FUND

The voluntary employees' beneficiary association established by the Trust Agreement to hold Plan assets and fund benefits paid by the Plan.

1.57. TRUST AGREEMENT

The document called the "Agreement and Declaration of Trust" which established the Trust Fund.

1.58. TRUSTEES, BOARD OF TRUSTEES

The individuals responsible for the operation of the Trust Fund in accordance with the terms of the Trust Agreement, together with the Trustees' successors. Trustees appointed by the Employer Association are Employer Trustees; Trustees appointed by the Union are Union Trustees.

1.59. UNIFORMED SERVICES

The United States Army, Navy, Marine Corps, Air Force, and Coast Guard, including their reserve components, and the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty; the commissioned corps of the Public Health Service; the commissioned officer corps of the National Oceanic and Atmospheric Administration; system members of the National Urban Search and Rescue Response System during a period of appointment into federal service; and any other category of persons designated by the United States president in time of war or national emergency.

1.60. UNION

Local Union No. 343, International Brotherhood of Electrical Workers ("IBEW"), AFL-CIO.

1.61. USERRA

The Uniformed Services Employment and Reemployment Rights Act of 1994, as it has been or hereafter may be amended.

1.62. WAITING PERIOD

The period of time that an individual must wait before being eligible for benefits under this Plan.

1.63. YOU, YOUR

"You" and "your" generally have the same meaning as Employee or Retiree as applicable. Also, they are the same as the term "Subscriber" as used in the context of the United Healthcare Program.

SECTION 2 ELIGIBILITY

SUMMARY

This Section of the booklet describes how you and your Dependents become eligible for benefits under the Plan, and the various ways you can maintain that eligibility.

2.1. ELIGIBILITY DEFINITIONS

2.1.1. Bargaining Unit Employee

An individual who is a member of a collective bargaining unit represented by the Union and who is an active Employee of a Contributing Employer.

2.1.2. Benefit Month

A period of one (1) calendar month during which an individual is Covered Under the Plan because he or she has met the eligibility requirements during the corresponding Eligibility Month.

2.1.3. Eligibility Month

A period of one calendar month during which an individual meets the eligibility requirements necessary to provide benefit coverage during the corresponding Benefit Month.

2.1.4. Helper/Pre-Apprentice

A full-time, non-excludable, Employee who is registered with the State of Minnesota as an unlicensed electrician doing electrical work and who has not begun or completed an electrician apprenticeship.

2.1.5. Non-Bargaining Unit Employee

An individual who is not a member of any collective bargaining unit represented by the Union and who is an Employee of a Contributing Employer.

2.1.6. Premium Credit Account

An account established for each Eligible Employee in the Plan and used to determine eligibility for benefits, act as an account for Self-Contributions required to continue benefits, and account for the accrual of any excess Contributions for that Eligible Employee.

If a Bargaining Unit Employee works more than the required hours to maintain coverage under the Plan, the excess Premium Credits are credited to the Bargaining Unit Employee's Premium Credit Account, up to a maximum of twelve (12) months' worth of Premium Credits.

2.1.7. Premium Credits

One Premium Credit for Bargaining Unit Employees (other than L.E.A. employees and employees working under the "Residential" Collective Bargaining Agreement) is equivalent to the current dollar amount to be contributed for each hour worked by a commercial journeyman wireman under the Inside Construction and Maintenance Collective Bargaining Agreement between IBEW Local

Union No. 343 and the National Electrical Contractors Association. L.E.A. employees' Premium Credit Accounts will be credited with one hundred thirty-five (135) Premium Credits per month, or the amount of the monthly premium paid by their Contributing Employer each month. The Premium Credit Accounts of Residential Employees will be credited with Premium Credits in excess of hundred fifty (150) Premium Credits per month.

Premium Credits are applied to provide eligibility for Employees and their Dependents. Premium Credits cannot be converted to cash.

2.1.8. Balance of Premium Credit Accounts

If an Employee has not opted out of Plan coverage consistent with the provisions of this Plan, any balance in a Premium Credit Account will be automatically applied against the cost of monthly premiums for both Bargaining Unit and Non-Bargaining Unit Employees for the purpose of maintaining coverage.

2.1.9. Forfeiture of Premium Credit Account

An accrued Premium Credit Account balance will be forfeited to the Plan upon the first to occur of any of the following:

A. Five (5) years from the date any individual's coverage under the Plan terminates.

B. Immediately upon the Plan's receipt of notice that a Bargaining Unit Employee is:

1. working as an employee of a non-union, non-contributing employer;

2. associated with a non-union, non-contributing employer in any capacity, including but not limited to working as an independent contractor or being a direct or indirect owner, or director and/or officer; or

3. not in good standing with IBEW Local 343.

C. The Trustees, in their sole discretion, may forfeit to the Plan the Premium Credit Account balance of an owner of a Contributing Employer that is delinquent in remitting Contributions on behalf of its non-owner employees and apply that amount against the delinquent Contributions on behalf of its non-owner employees.

2.2. INITIAL ELIGIBILITY REQUIREMENTS FOR BARGAINING UNIT EMPLOYEES (OTHER THAN LIMITED ENERGY ASSOCIATION ("L.E.A.") EMPLOYEES)

A Bargaining Unit Employee (other than a L.E.A. employee) becomes initially eligible for benefits a few months after first earning enough Premium Credits to pay for a month of coverage. A New Employee—one who has not been eligible for coverage under the Plan as a Bargaining Unit Employee in the last five (5) years—may also choose to become initially eligible earlier, by timely paying one-hundred percent (100%) of the monthly cost of coverage out-of-pocket. This Section of the booklet explains the rules regarding eligibility.

Please note: All Self-Contributions must be timely paid or coverage under the Plan will terminate.

2.2.1. Initial Eligibility: General Rule

It takes 135 Premium Credits to pay for one (1) month of coverage, although the Trustees in their sole discretion may change that number. Once the Plan has received one hundred thirty-five (135) Premium Credits on behalf of a Bargaining Unit Employee, the timer is set for initial eligibility. If the Plan receives the 135th Premium Credit in a particular month (say, April), that month is considered an Eligibility Month under the table below. Coverage would begin on the first day of the corresponding Benefit Month (in this case, July).

If a Bargaining Unit Employee has a negative Premium Credit Account balance on the date of hire, due to prior coverage under the Plan, any Premium Credits received by the Plan are first applied against any negative balance of the Bargaining Unit Employee's Premium Credit Account until the Premium Credit Balance is back to zero. After the Premium Credit Account balance is back to zero, the Plan must receive one hundred thirty-five (135) additional Premium Credits on behalf of that Bargaining Unit Employee to set the timer for initial eligibility.

Premium Credits earned in **ELIGIBILITY MONTH**	***Provide Eligibility in*** **BENEFIT MONTH**
January	April
February	May
March	June
April	July
May	August
June	September
July	October
August	November
September	December
October	January
November	February
December	March

2.2.2 Initial Eligibility: Buy-In Option for New Employees

A. Initial Eligibility. A "New Employee" is a Bargaining Unit Employee who was not eligible for benefits under the Plan as a Bargaining Unit Employee for at least five (5) years before his or her date of hire. A new Employee's coverage will begin under the Initial Eligibility General Rule unless the New Employee exercises the Buy-In Option in Paragraph (B) below.

EXAMPLE

ASSUME JOHN WAS COVERED UNDER THIS PLAN AS BARGAINING UNIT EMPLOYEE THROUGH JULY 2019. HE LEFT THE TRADE FOR A FEW YEARS AND RETURNED TO WORK FOR A CONTRIBUTING EMPLOYER IN FEBRUARY 2021.

JOHN ***IS NOT*** A NEW EMPLOYEE, BECAUSE HE WAS ELIGIBLE FOR COVERAGE UNDER THE PLAN AS A BARGAINING UNIT EMPLOYEE WITHIN THE PREVIOUS FIVE (5) YEARS. JOHN MAY NOT CHOOSE THE BUY-IN OPTION FOR NEW EMPLOYEES BUT MUST INSTEAD FOLLOW THE GENERAL RULE FOR INITIAL ELIGIBILITY.

B. Buy-in Option. Instead of waiting for coverage to begin under the Initial Eligibility General Rule, a New Employee may choose to start coverage earlier by paying out-of-pocket (the "Buy-in Option"). A New Employee may elect to take the Buy-in Option by selecting it on the Eligibility Election Form provided during the job referral process at the Union hiring hall. That form is also available from the Administrative Manager. Once the Plan has received eighty (80) Premium Credits on behalf of a New Employee, the New Employee may make Self-Contributions for initial eligibility. If the Plan receives the 80th Premium Credit in a particular month (say, April), coverage may begin on the first day of any later Benefit Month (for example, May), as long as the New Employee makes Self-Contributions by the sixteenth (16th) day of that Benefit Month.

The amount of the Self-Contributions required can be as high as the entire current premium for a Benefit Month. That would occur when a New Employee buys coverage for a Benefit Month (say, May), but the Plan received no Premium Credits for the corresponding Eligibility Month (that is, the prior February, according to the table above). If the Plan *had* received Premium Credits for that corresponding Eligibility Month, the amount of the Self-Contributions would be reduced by those Premium Credits.

There is a time limit for exercising the Buy-in Option. A New Employee who within two (2) months of his or her date of hire has neither exercised the Buy-in Option, nor otherwise become eligible for coverage under the Plan may not make Self-Contributions for initial eligibility.

2.2.3. Eligibility Statement

The Administrative Manager will send an Eligibility Statement to the Employee if a Self-Contribution is due, advising of the status of the Employee's Premium Credit Account and number of Premium Credits reported for the Employee in the prior calendar month. As described in the Continuing Eligibility Rules, below, if the balance of Premium Credits in the Employee's Premium Credit Account is insufficient to maintain eligibility, the Employee will be advised by the Eligibility Statement of the amount of the Self-Contribution which he or she must make in order to maintain eligibility and the payment plans which are available. The Administrative Manager will not send an Eligibility Statement if Self-Contributions are not due for a particular month.

If an Employee is required to make Self-Contributions due to delays in the transfer of "reciprocity monies" from another local union, or because his or her Employer's Contributions are delinquent, the Employee must pay the Self-Contribution by the due date in order to be Covered Under the Plan for the applicable Benefit Month. Failure to do so will result in termination of coverage under this Plan. Reciprocal amounts and delinquent Employer Contributions which are later paid to the Plan will be applied to the affected Employee's Premium Credit Account.

The Employee has one year from the date of issuance of any Eligibility Statement to submit a request for a correction of any mistakes, inaccuracies, or omissions in the Eligibility Statement.

Each quarter, a Summary Statement of Benefits Received will be sent to Employees.

2.3. CONTINUING ELIGIBILITY FOR BARGAINING UNIT EMPLOYEES (OTHER THAN L.E.A. EMPLOYEES)

2.3.1. Minimum Hours

To continue to be eligible, the Employee must be credited with Premium Credits equal to at least one (1) month's premium each "Eligibility Month" or make the equivalent Self-Contribution for coverage in the corresponding Benefit Month. Excess Contributions will be credited to the Employee's Premium Credit Account until a maximum balance of twelve (12) months of Premium Credits is reached.

2.3.2. Self-Contributions

An Employee who is not Actively at Work and does not have enough Premium Credits in his or her Premium Credit Account may make Self-Contributions for up to eighteen (18) months of health care coverage by paying the applicable premium to the Plan at the Administrative Manager's office. Premium payments are due by the last day of the month preceding the Benefit Month for which coverage is to be effective. This Self-Contribution period will end earlier if the Employee becomes covered under another group health care plan, works for a non-contributing employer in the industry, or fails to timely remit payment of the required Self-Contribution amount. If the Employee re-qualifies with Premium Credits equal to or exceeding one (1) month's premium, that event will start a new eighteen (18) month period of "Self-Pay" Eligibility.

Employees electing not to make Self-Contributions for insufficient Premium Credits will have their eligibility terminated at the beginning of the next Benefit Month and will have to re-qualify under the Plan's rules for Initial Eligibility. Any amounts that remain in the Employee's Premium Credit Account will be frozen until the Employee re-qualifies. Individuals who are no longer available for work lose their eligibility for health care benefits and their Premium Credit Accounts will be frozen until the Employee re-qualifies.

The right to make Self-Contributions is in addition to the right to continue coverage under COBRA (See the Section of this booklet entitled "Continuation Coverage Under COBRA").

2.4. ELIGIBILITY REQUIREMENTS FOR L.E.A. EMPLOYEES

2.4.1. Participation by L.E.A. Employees

Employees working under the Collective Bargaining Agreement between the L.E.A. and IBEW Local Union No. 343 ("L.E.A. Agreement") will be eligible to participate in this Plan if a majority of the L.E.A. employees of any Employer elect this option (under election rules set forth in the L.E.A. Agreement) and subject to the following rules.

2.4.2. Initial Eligibility

L.E.A. employees will become eligible for coverage under the Plan on the first day of the month following the first day of employment with their Employer, or, if later, the first day of the month following an election by an Employer's L.E.A. employees to participate in this Plan. Employees will not become Covered Under the Plan until the required Employer Contributions and payroll deductions are received by the Plan.

2.4.3. Monthly Eligibility

Eligibility for L.E.A. employees is determined on a calendar month basis. Contributions must be post-marked or received by the Administrative Manager on or before the fifteenth (15th) day of the month preceding the Benefit Month for which coverage is to be effective or the first following business day if the fifteenth (15th) day of the month falls on a weekend or holiday (the "Due Date"). Contributions due in any month provide eligibility for that same calendar month. L.E.A. employees' Premium Credit Accounts will be credited with 135 premium credits per month, or the amount of the monthly premium paid by their employer each month.

2.4.4. Continuing Eligibility

L.E.A. employees will remain Covered Under the Plan as long as they continue to be employed in a position covered by the L.E.A. Agreement for all or any portion of a month and the required Employer Contributions and payroll deductions are submitted in a timely manner to the Plan. In the event of a mid-month separation from employment, the L.E.A. employee's coverage will continue for the remainder of the month for which a premium has been received.

2.4.5. Termination of Coverage

L.E.A. employees (and their Dependents) whose coverage will terminate may be allowed to continue their coverage by making Self-Contributions to the Plan for up to eighteen (18) months of health care coverage by paying the applicable premium on a timely basis to the Administrative Manager. This Self-Contribution period will end earlier if the L.E.A. employee becomes covered under another group health care plan, works for or becomes associated with a non-contributing employer in the industry, or fails to timely remit payment of the required Self-Contribution amount. (See Section 2.1.9 Forfeiture of Premium Credit Account).

If the L.E.A. employee requalifies for coverage under this Plan, that event will start a new eighteen (18) month period of "Self-Contribution Eligibility."

The right to make Self-Contributions for eighteen (18) months is in addition to the right to continue coverage under COBRA (See the Section of this booklet entitled "Continuation Coverage Under COBRA").

2.4.6. Employer Contributions and Payroll Deductions

Coverage under this Plan for L.E.A. employees is provided through Employer Contributions and payroll deductions. As a result, Employers will deduct from each L.E.A. employee's wages the amount established in the applicable L.E.A. Agreement. The Employer must send these amounts to the Administrative Manager. These payments must be received by the Administrative Manager's Office by the fifteenth (15th) day of the month preceding the Benefit Month for which coverage is to be effective. Your Employer's failure to makes the necessary Contributions in a timely manner will result in termination of coverage.

2.5. ELIGIBILITY REQUIREMENTS FOR INDIVIDUALS COVERED UNDER THE PLAN PURSUANT TO A PARTICIPATION AGREEMENT

2.5.1. Contributions

Contributions are required and must be received by the Administrative Manager by the fifteenth (15th) day of the Benefit Month for which coverage is to be effective or the first following business

day if the fifteenth (15th) day of the month falls on a weekend or holiday (the "Due Date"). Failure to timely make the Contribution will result in termination of coverage. It is not the responsibility of the Administrative Manager to notify Non-Bargaining Unit Employees of any Contribution payment which is due. This Contribution period will end early if the Non-Bargaining Unit Employee becomes covered under another group health plan.

Former Bargaining Unit Employees who become owners of Employers who are signatory to a Collective Bargaining Agreement providing for Contributions to the Plan ("Non-Bargaining Unit Employees" or "Working Owners"), and who are also signatory to Participation Agreements covering Non-Bargaining Unit Employees, may apply their positive Premium Credit Account balance against the premiums required to maintain coverage under the Plan. The Participation Agreement will govern the extent to which a Non-Bargaining Unit Employee or Working Owner is eligible for benefits under this Plan. Non-Bargaining Employees and Working Owners must pay the full Contribution amount for Bargaining Unit Employees in order to be eligible to participate in this Plan.

2.5.2. Effective Date of Coverage for Non-Bargaining Unit Employees

A Non-Bargaining Unit Employee will be eligible to be Covered Under the Plan on the first (1st) day of the month following the date of hire or on the first (1st) day of the month following the date a Participation Agreement is signed if the Plan timely receives the required Contributions.

2.5.3. Employers Electing Non-Bargaining Coverage

Employers and Working Owners electing to cover their Non-Bargaining Unit Employees, are required to cover all Non-Bargaining Unit Full-Time Employees.

2.5.4. Termination of Employment or Other Loss of Coverage

Non-Bargaining Unit Employees whose employment is terminated or experience a loss of eligibility for another reason may be allowed to continue their coverage by making Self-Contributions to the Plan for a period of eighteen (18) months. The right to make Self-Contributions for eighteen (18) months is in addition to the right to continue coverage under COBRA. (See the Section of this booklet entitled "Continuation Coverage Under COBRA").

2.5.5. Electrical Inspectors

Employees who were Covered Under the Plan as Bargaining Unit Employees at the time they become employed or engaged as inspectors in the electrical industry, and do not enter into a Participation Agreement with the Plan, may continue their benefits under this Plan by making Self-Contributions until the earlier of: (i) eighteen (18) months; or (ii) termination of employment or engagement as an inspector. The right to make Self-Contributions for eighteen (18) months is in addition to the right to continue coverage under COBRA (See the Section of this booklet entitled "Continuation Coverage Under COBRA").

These individuals will have the same benefit levels as a regular Bargaining Unit Employee and may utilize their remaining Premium Credit Account Balance in accordance with the terms of the Plan.

2.6. ELIGIBILITY DURING DISABILITY (BARGAINING UNIT EMPLOYEES ONLY)

If a Bargaining Unit Employee is unable to perform work because he or she is Totally Disabled, the Bargaining Unit Employee may be able to maintain eligibility for coverage under the Plan for a maximum period of six (6) months ("Maximum Benefit Period"). If the Employee becomes Totally Disabled while working for an Employer who is not signatory to a Collective Bargaining Agreement, this disability provision will not apply. If a Bargaining Unit Employee is eligible to continue coverage while Totally Disabled, he or she is subject to the following rules:

A. This Eligibility During Disability provision applies to non-work-related disabilities, and to work-related disabilities if the Bargaining Unit Employee becomes Totally Disabled on a job while working for an Employer who is making Contributions to the Plan on the Employee's behalf based upon a Collective Bargaining Agreement. If the Employee becomes Totally Disabled on the job while working for an Employer who is not signatory to a Collective Bargaining Agreement, this disability provision will not apply.

B. Proof of Total Disability must be sent to the Administrative Manager.

C. If the Employee recovers in the same month in which Total Disability began, the Employee will be eligible in the Benefit Month closest to the Eligibility Month in which Total Disability occurred, provided the Employee would have been eligible under the Plan had the Employee actively worked for a Contributing Employer during the period of Total Disability.

D. If eligibility is continued under this provision and the Employee returns to employment for a Contributing Employer before the end of the Maximum Benefit Period, the Employee's eligibility will continue for the balance of the Benefit Month in which the Employee returns to work on a continuously active basis.

E. If an Employee has been covered under this provision for the entire Maximum Benefit Period and is still Totally Disabled and unable to return to work, or if the Employee recovered from his or her Total Disability but there is no work available in his or her area, the Employee may continue to make Self-Contributions for the period allowed by the Plan. After that, the Employee and the Employee's Dependent's may be entitled to COBRA Continuation Coverage by making COBRA Self-Contributions. Refer to the "Continuation Coverage Under COBRA" Section of this booklet for more information.

F. If the Employee recovers from his or her Total Disability while covered under this provision, does not work for a Contributing Employer, and is not available for work with a Contributing Employer, the Employee's coverage under the Plan will end on the date the Employee is no longer Totally Disabled or the date the Employee's coverage ends under the continuing eligibility rules of the Plan, unless the Employee makes the correct and on-time Self-Contributions.

G. After the first six (6) months of disability, the Totally Disabled Employee may make Self-Contributions at the established applicable rate. An Eligible Employee may re-establish a new "6 month benefit" by: (i) completing six (6) months of continuous active employment as an Employee with a Contributing Employer; or (ii) if the Employee had provided a written statement satisfactory to the Plan signed by the Employee's attending Physician that the Employee was released to return to work and able to perform all of the duties of his or her employment, and Eligible Employee sustains a subsequent Total Disability that is completely unrelated to any prior Injury or Sickness for which the Eligible Employee received disability benefits under the Plan.

H. If an Employee is Totally Disabled and the Employee's Total Disability constitutes a Permanent and Total Disability, as evidenced in a determination letter to the Employee from the Social Security Administration indicating the Employee is eligible for social security disability benefits, the Employee can apply to the Plan to continue coverage as a Retiree under the Retirees Benefit Section.

I. Life Benefits under the Plan will remain in force until the Employee is no longer Totally Disabled or attains age sixty-five (65), whichever occurs earlier.

2.7. RECIPROCITY

Many times employees in the electrical industry may perform work in the geographical jurisdiction of different IBEW-affiliated local unions. Normally, this would result in contributions being made on behalf of an employee to two (2) or more health funds. If this occurred, the employee might not be able to establish eligibility in any one of those funds.

The South Central Minnesota Electrical Workers' Family Health Plan participates in two (2) different programs that are designed to avoid this problem. For Employees working within the jurisdiction of IBEW Local Unions 110 or 292, the Plan will accept contributions directly from the employer under the provisions of the Minnesota Portability Agreement (the "Minnesota Agreement"). For Employees working within the jurisdiction of other local unions, the Plan participates in the Electrical Industry Welfare Reciprocal Agreement (the "National Agreement"), a national reciprocity agreement for electrical workers. Each of these agreements is described in more detail below.

2.7.1. The Minnesota Portability Agreement

If your home local is IBEW Local Union No. 343, but you are employed in the jurisdictions of IBEW Local Unions No. 110 or 292, the Minnesota Portability Agreement provides that your employer will report hours worked and send contributions to this Plan. This will assure that you receive credit in one plan, this Plan, for all work you perform within the jurisdiction of these three (3) locals. Alternatively, under the Minnesota Portability Agreement, you have the option to direct your employer to report hours to the fund situated in the jurisdiction of the local in which your work was performed. Those contributions will then be handled according to the provisions for reciprocity of contributions under the National Reciprocity Agreement described below.

2.7.2. National Agreement Definitions

Definitions: For purposes of this Subsection, the following terms will have the following meanings:

A. Home Fund or Funds. An individual's Home Fund(s) is:

1. The Participating Fund or Funds in which the individual is a participant; or

2. If the individual is not a member of an IBEW local union, or, if the individual's local union does not have a welfare fund, then, the Home Fund will be the Participating Fund in which the individual is currently a participant at the time an authorization form is filed requesting reciprocity.

B. Participating Fund. A jointly administered welfare fund which is signatory to the Reciprocal Agreement and covers employment within the jurisdiction of an IBEW local union.

C. Temporary Employee. An individual temporarily employed outside the jurisdiction of the Home Fund and within the jurisdiction of another Participating Fund. However, the individual will not be covered by the terms of the Reciprocal Agreement unless the fund is a signatory to that Agreement.

2.7.3. How a Temporary Employee Elects Reciprocity

If you are a Temporary Employee and you are employed within the area of a Participating Fund, you may ask the Participating Fund to have an amount of money equal to the contributions made on your behalf to be transferred to your Home Fund. To make such a request, you must complete a Blanket Authorization on the Electronic Reciprocity Transfer System ("ERTS") at any local union office or at the Fund Office.

Among other things, the Blanket Authorization will release the trustees of the Participating Fund from any claim, by the Temporary Employee or anyone making a claim through the Temporary Employee, based on the contributions made after the authorization.

2.7.4. Amount of Transfer to the Home Fund

The Participating Fund will transfer to the Temporary Employee's Home Fund an amount of money equal to hours worked at the Home Fund rate or at the Participating Fund's rate, whichever is less. There will be no administrative fee charged by the Participating Fund for the transfer or for any other reason.

2.7.5. How to Stop Transfers

If the Temporary Employee decides to stop the transfer of monies from a Participating Fund to the Home Fund, the Temporary Employee must complete a Cessation of Transfer on the ERTS system. The Cessation of Transfer request will become effective on the last day of the month following the month in which the Temporary Employee completes the Cessation of Transfer.

2.7.6. When Reciprocity is not in Effect

When a Participating Fund receives contributions for a Temporary Employee, the contributions will NOT be transferred but will be applied according to the Participating Fund's provisions, if:

A. The Temporary Employee has not completed a Blanket Authorization on the ERTS; or

B. The Temporary Employee has not established a Home Fund.

2.8. OPT-OUT FOR HEALTH SAVINGS ACCOUNT (HSA) COVERAGE

A Dependent of an Eligible Employee may elect to opt-out of coverage under this Plan if he or she is eligible for a health plan offered by his or her employer that is a high deductible health plan with a Health Savings Account (HSA/HDHP). The Dependent must submit to the Administrative Manager a completed "Application to Waive Coverage in Favor of Other Available Coverage Under a High Deductible Health Plan and Health Savings Account" form to opt-out of coverage under this Plan.

By electing to opt-out of coverage under the Plan the Dependent will:

A. Not be entitled to any benefits or other payments from the Plan, including, but not limited to, health care benefits, pharmacy benefits, or extended coverage options under federal law.

B. Have no right or claim to any Contributions made to the Plan for the purposes of funding the Dependent's eligibility for coverage.

C. Forfeit any right to benefits under the Plan even if Plan benefits are superior in some respects to the benefits under the HSA/HDHP offered by the Dependent's employer.

D. Return to coverage under the Plan only if:

1. The Dependent loses coverage under the HSA/HDHP and:

   a. Applies in writing to return to Plan coverage:

      i. Within thirty-one (31) days after losing the HSA/HDHP coverage, or

      ii. During the Plan's annual open enrollment period (which is December 1-31 of each Calendar Year for reinstatement effective January 1 of the next succeeding Calendar Year), and

   b. The Dependent otherwise meets the eligibility requirements of the Plan; or

2. The Eligible Employee dies and the Dependent then:

   a. Applies to return to Plan coverage:

      i. Within thirty-one (31) days after the Eligible Employee's death, or

      ii. During the Plan's first open enrollment period (December 1-31 of each Calendar Year) after the Eligible Employee's death for reinstatement effective January 1 of the next succeeding Calendar Year), and

   b. The Dependent otherwise meets the eligibility requirements of the Plan (determined as if the Eligible Employee were still living).

An Employee or Dependent can obtain the "Waiver of Coverage" form and the Application form to return to Plan coverage from the Plan Administrator. The Dependent must indicate the date upon which the waiver of coverage will be effective.

2.9. EXHAUSTION OF PREMIUM CREDIT ACCOUNT FOR TAKING CERTAIN NEW JOBS

If you leave employment covered by the Plan with a Contributing Employer, and then you work for an employer, or as an employer, independent contractor, partner, or sole proprietor that does not contribute to the Plan but is engaged in the electrical industry within a geographic area covered by the Electrical Industry Health and Welfare Reciprocal Agreement, the Plan may reduce the balance in your Premium Credit Account to zero. You will then have no right to continue

to be covered by the Plan, except the right to elect COBRA Continuation Coverage if you are legally entitled to do so.

2.10. DEPENDENTS OF A DECEASED EMPLOYEE

If you, (the Employee), die while Covered Under the Plan, any coverage then in force for your Eligible Dependents may be continued if your Dependents pay the required Self-Contributions (refer to the Self-Contributions heading in this Section). The Dependents of a Bargaining Unit Employee will be allowed to use any Premium Credits remaining in the deceased Bargaining Unit Employee's Premium Credit Account at the time of death.

The Self-Contribution period for Dependent coverage, including your Spouse's, will terminate on the first date when any of the following occur and the Dependent will not be allowed to re-enroll at a later date:

A. The Spouse is remarried;

B. The Dependent becomes eligible for medical coverage under any other group health care plan;

C. The Dependent ceases to meet this Plan's definition of a Dependent, unless the Dependent is entitled to enroll and does enroll for COBRA Continuation Coverage (refer to "Continuation Coverage Under COBRA" Section in this booklet);

D. The date at the end of the last day of the thirty-six (36)-month period for which correct and on-time Self-Contributions have been made for Continuation Coverage under COBRA, or on the date of occurrence of any event stated in the "Continuation Coverage Under COBRA" Section in this booklet which causes that coverage to terminate;

E. The Trustees discontinue Dependent coverage for the class of Employees of which the Employee was a member immediately prior to death;

F. If Self-Contributions are required, the end of the period for which the correct Self-Contributions have been timely made; or

G. The Plan terminates.

If your child is born after your death, that child may be covered as a Dependent on the same basis as other Dependents are Covered Under the Plan.

If the surviving Spouse elects to continue coverage through Self-Contributions, the surviving Spouse of an Eligible Employee must pay the entire Self-Contribution amount until he or she reaches age sixty-two (62) and then may pay the Retiree rate (See the Subsection entitled "Retirees" in this Section) that would have applied if the Employee lived until that time.

2.11. MILITARY SERVICE

An Eligible Individual must inform the Administrative Manager in writing as soon as the Eligible Individual knows that he or she is entering Military Service.

A. For Dependents Entering into Military Service. Coverage for a Dependent will cease on the date that Dependent enters Military Service.

B. For Bargaining Unit Employees Entering into Military Service. Bargaining Unit Employees entering into Military Service (and their Dependents) may elect to have their coverage frozen during Military Service (see "Freezing Coverage", below) or may elect to continue coverage during that period (see "Military Continuation Coverage", below).

C. Freezing Coverage. Unless you (the Employee) or your Dependents choose to continue coverage as described below, coverage for you and your Dependents will discontinue on the date **you** enter Military Service. Your eligibility status will be "frozen" when you enter Military Service and will be fully restored when you are honorably discharged and return to work with a Contributing Employer within the permitted time limits. Please refer to the Section entitled "Coverage Following Military Service" below for information about the time limits for returning to work.

D. Military Continuation Coverage. Once the Plan Administrator has been notified that you are entering Military Service, you and your Dependents will be allowed to purchase Military Continuation Coverage. You can continue coverage for up to twenty-four (24) months. That coverage will be provided as follows:

1. The election procedures and coverage options will be the same as those that are available under Continuation Coverage under COBRA Please refer to the Section entitled "Continuation Coverage Under COBRA" Section above for more information.

2. A Bargaining Unit Employee may elect to freeze his or her Premium Credit Account and make Self-Contributions to purchase this coverage for up to twenty-four (24) months. Eligibility will be automatically reinstated for Bargaining Unit Employees who choose this option when the Bargaining Unit Employee is honorably discharged from Military Service and returns to employment with a Contributing Employer within the permitted time limits. Please refer to the Section entitled "Coverage Following Military Service" below for information about the time limits for returning to work.

3. Alternatively, a Bargaining Unit Employee may first exhaust his or her Premium Credit Account to continue coverage, and then make Self-Contributions for up to another twenty-four (24) months of Military Continuation Coverage. The eligibility status for a Bargaining Unit Employee who chooses this option will not be frozen. Following discharge, a Bargaining Unit Employee will need to satisfy the initial eligibility requirements of the Plan to be Covered Under the Plan again. However, as indicated under the Subsection "Coverage Following Military Service" below, a Bargaining Unit Employee may make Self-Contributions to continue coverage upon return from leave for Military Service.

4. You must submit payment of the Self-Contributions to the Plan Administrator by the first day of each month (the "due date"). If a payment is not received within thirty (30) days of that due date, Military Continuation Coverage will be retroactively terminated to the due date.

E. Termination of Military Continuation Coverage. Military Continuation Coverage will cease on the earliest of:

1. The first day of the month for which a required and on-time Self-Contribution is not received; or

2. The end of twenty-four (24) months of self-paid Military Continuation Coverage (not including coverage obtained through the application of your Premium Credit Account); or

3. The day after the last date on which you are required to apply for or return to a position of employment with a Contributing Employer (see the chart entitled "Time Limits to Return to Work," below).

F. Coverage Following Military Service. If you do not elect Military Continuation Coverage (freeze your coverage), or if you do not use your Premium Credit Account to pay for that coverage, your eligibility status is frozen when you enter Military Service provided you have notified the Administrative Manager of that service. If you and your Dependents were eligible for coverage when you entered active duty, you again will be covered when you are honorably discharged and return to work for a Contributing Employer or sign the book indicating that you are available for, but unable to get, such work within the time limits provided below. You must be honorably discharged to be eligible to have your frozen eligibility status restored.

If you exhausted your Premium Credits to pay for coverage while on leave for Military Service, were honorably discharged, and you return to work for a Contributing Employer within the time limits provided below, you may make Self-Contributions to resume your eligibility for coverage under the Plan until such time as sufficient Contributing Employer Contributions for coverage have been credited to your Premium Credit Account. Contact the Administrative Manager to determine your Premium Credit Account balance and learn what activity took place in your account during your Military Service. These time limits may be extended if you have suffered a service-connected injury or illness. You should contact the Administrative Manager if that has occurred.

G. Time Limits to Return to Work.

If you were in Military Service	You must
1 to 30 days	Report to your Employer (or another Contributing Employer) by the beginning of the first regularly scheduled work day commencing more than eight (8) hours after you return home.
31 to 180 days	Submit an application for reemployment to your Employer (or another Contributing Employer) within fourteen (14) days after the completion of your service.
More than 180 days	Submit an application for reemployment to your Employer (or another Contributing Employer) within ninety (90) days after the completion of your service.

If you do not return to work with the same Contributing Employer, you should notify your Local Union that you are available for work with a Contributing Employer. Also, you must

submit your discharge papers to the Plan Administrator within fourteen (14) days of the date you return to work for a Contributing Employer.

2.12. FAMILY AND MEDICAL LEAVE

Under the Family and Medical Leave Act of 1993 (the "FMLA"), you may be entitled FMLA leave for up to twelve (12) weeks if you are away from work due to a Qualifying Condition (defined below). You will only be eligible for FMLA leave if you have worked for a Contributing Employer for at least one year, and you have worked at least 1,250 hours for the same Contributing Employer over the previous twelve (12) months. Your Contributing Employer is responsible for determining your eligibility for FMLA leave.

Even if you are not eligible for FMLA through your Employer (e.g., you have not worked for the same Contributing Employer for the previous twelve (12) months), you may be eligible to continue coverage under the Plan if you satisfy the requirements in the following section ("Continued Coverage Due to a Qualifying Condition"). This option to continue Plan coverage is a Plan benefit and is separate and distinct from any rights or protections you may have under FMLA.

2.12.1. Reasons for Taking Leave

You may be entitled to twelve (12) work-weeks of coverage in a twelve (12) month period under the FMLA if your leave is due to any of the following reasons:

A. For your incapacity due to pregnancy, prenatal medical care or child birth;

   1. To care for your child after the birth, or the placement of a child with you for adoption or foster care, provided that the leave is taken within one year of the birth or placement. In the event that both you and your Spouse are covered by this Plan, the continued coverage to care for a newborn or a child placed with you for adoption or foster care will not exceed a total of twelve (12) weeks;

B. To care for your Spouse, child, foster child, adopted child, stepchild or parent who has a serious health condition;

C. For a serious health condition that makes it impossible for you to perform your job duties;

D. Military Care Giver Leave to care for a parent, Spouse, child, or relative to whom the Employee is next of kin when the family member is a veteran who served in the armed forces (including a member of the National Guard or Reserves) at any time during the period of five (5) years before the date the veteran undergoes the medical treatment, recuperation or therapy; and

E. Qualifying Exigency Leave covers members of the regular armed forces who are deployed to a foreign country. For members of a regular component of the armed forces, covered active duty means duty during deployment to a foreign country. For members of the Reserves, it means duty during deployment to a foreign country under a call or order to active duty pursuant to specified provisions of federal law. In order for an Employee to qualify for qualifying exigency leave, the Employee's Spouse, son, daughter or parent must be on "covered active duty." Qualifying exigencies include:

   1. Short-notice deployment;

2. Military events and related activities;

3. Childcare and school activities;

4. Financial and legal arrangements;

5. Counseling;

6. Rest and recuperation;

7. Post-deployment activities; and

8. Additional activities to which the Employer consents.

F. You may be entitled to twenty-six (26) work-weeks of coverage in a twelve (12) month period under the FMLA if your leave is to care for a service member whose serious illness or injury was incurred before the active duty but was aggravated by military service in the line of active duty. For veterans, a serious illness or injury is a "qualifying illness or injury" that was incurred in the line of duty on active duty in the armed forces and that manifested itself before or after the service member became a veteran. Only where the serious illness or injury rises to the level of a subsequent illness or injury will an Employee be entitled to take leave for the same covered service member.

2.12.2. Advanced Notice and Medical Certification

If your Employer determines you are eligible for FMLA leave Plan Coverage, the Plan may require you to provide advanced notice and medical certification before leave Plan Coverage is granted. FMLA leave Plan Coverage may be denied if the following requirements are not satisfied:

A. You must provide the Plan with thirty (30) days advance notice of your intent to take FMLA leave when it is foreseeable;

B. The Plan may require you to provide medical certification to support a request for leave due to a serious health condition; and

C. The Plan may require second or third opinions (at the Plan's expense).

If you have any questions regarding Plan Coverage during an FMLA leave, please contact the Administrative Manager.

2.13. RETIREES

2.13.1. Continuing Coverage

The following provisions describe Retiree eligibility factors, coverage available to Retirees, and the cost for that coverage. Individuals who became eligible for Retiree coverage under a prior set of rules will be entitled to continue their coverage under the more favorable of the prior set of rules or these rules, as elected by the Retiree.

A. Bargaining Unit Retirees. Retirees who are Bargaining Unit Employees at the time of their retirement, who (1) are at least age fifty-five (55) when they retire, (2) who are eligible to receive and are receiving a pension from either NEBF or IBEW retirement plans or the South Central Minnesota Electrical Workers' Retirement and 401(k) Plan, and (3) who

satisfy one of the following service requirements, will be entitled to continue health benefits in this Plan by making timely Self-Contributions at the applicable rate. Service requirements include:

1. The Retiree has been Covered Under The Plan for at least 360 Benefit Months, including the Benefit Month in which the Employee retires;

2. The Retiree has been Covered Under The Plan for at least 240 Benefit Months, including the Benefit Month in which the Employee retires, and at least twelve (12) of the sixty (60) Benefit Months immediately preceding his or her retirement; or

3. The Retiree has been Covered Under the Plan for at least 120 Benefit Months, including the Benefit Month in which the Employee retires, and at least twenty-four (24) of the sixty (60) Benefit Months immediately preceding his or her retirement.

Periods of coverage attributable to disability status, or to COBRA continuation coverage will not apply towards satisfying these service requirements. Regardless of any provision of this Summary Plan Description that might say otherwise, a month during which you were covered under the Emergency medical program will count as neither: (i) a Benefit Month during which you were Covered Under The Plan, for purposes of determining whether you satisfy the service requirements for eligibility for Retiree benefits; nor (ii) as a month of coverage under the Plan, for purposes of determining any discount on the cost of any Retiree coverage for which you might otherwise be eligible.

B. Non-Bargaining Unit Retirees. Retirees who are Non-Bargaining Unit Employees or Inspectors at the time of their retirement, who: (i) are at least age fifty-five (55) when they retire; (ii) are eligible to receive a pension from either NEBF or IBEW retirement plans; (iii) are receiving a pension from the South Central Minnesota Electrical Workers' Retirement and 401(k) Plan (if one is available); and (iv) have participated on a Self-Contribution basis for at least 120 Benefit Months, and at least twenty-four (24) of the sixty (60) Benefit Months immediately preceding retirement, will be entitled to continue health benefits in this Plan by making timely Self-Contributions at the applicable rate.

Retirees not meeting the above requirements or not electing to be covered under these Retiree provisions will be treated like any other terminated Employee, except for Retirees who meet the above requirements and elect to Temporarily Opt-Out of Retiree Benefits Coverage. (See the Sections of this booklet entitled "Initial Eligibility Requirements for Bargaining Unit Employees (other than L.E.A. Employees)" and "Option to Temporarily Opt-Out of Retiree Benefits Coverage").

EXAMPLE

JOE RETIRED IN JANUARY 2020 AT AGE SIXTY-ONE (61). AT THAT TIME, HE BEGINS TO RECEIVE BENEFITS FROM THE SOUTH CENTRAL MINNESOTA ELECTRICAL WORKERS RETIREMENT AND 401(K) PLAN.

JOE HAD BEEN COVERED BY THIS PLAN FOR 156 BENEFIT MONTHS DURING HIS CAREER EXCLUDING PERIODS OF COVERAGE DUE TO DISABILITY OR COBRA CONTINUATION COVERAGE. HE HAD ALSO BEEN COVERED FOR THIRTY-NINE (39) OF THE LAST SIXTY (60) BENEFIT MONTHS IMMEDIATELY PRIOR TO HIS RETIREMENT.

JOE WOULD BE ELIGIBLE AT THE TIME OF HIS RETIREMENT TO CONTINUE COVERAGE

UNDER THIS PLAN AS A RETIREE.

TO DO SO, JOE MUST ADVISE THE PLAN ADMINISTRATOR OF HIS ELECTION AND MUST TIMELY MAKE ALL REQUIRED SELF-CONTRIBUTIONS.

2.13.2. Coverage for Eligible Retirees

A. There is no Weekly Income Disability Benefit or Life Benefit for any Retiree.

B. Retirees under age sixty-five (65) have the same Hospital and major medical benefits as they had prior to retirement. Retirees over age sixty-five (65) have a Medicare supplemental benefit that is coordinated with the benefits payable by Medicare. These individuals will be reimbursed the same as someone under age sixty-five (65), but Medicare will pay first. See the Section of this booklet entitled "Retiree Benefits."

C. A Totally Disabled (as defined in the "Definitions" Section of this booklet) Employee who cannot be retrained or re-employed will be eligible for Retiree Benefits (upon approval of the Board of Trustees) regardless of age, subject to the following rules:

1. This provision covers only Eligible Employees in the Plan;

2. The Employee need not be eligible to receive a retirement benefit from the NEBF, IBEW, or South Central Minnesota Electrical Retirement and 401(k) Plan to be eligible for this benefit;

3. The Employee need not have been Covered Under The Plan for any specific length of time prior to becoming Totally Disabled, but a rate subsidy will reduce the amount of required Self-Contribution for Employees who have been covered longer under the Plan; and

4. The Employee must obtain a Social Security Disability Award prior to becoming eligible for these Retiree Benefits.

D. Retirees who, on the date of retirement, are married yet elect Retiree single coverage may apply for reinstatement of spousal Dependent coverage on the Spouse's retirement date provided that:

1. The Retiree's Spouse was covered under another group health care plan maintained by an employer on the date of the Retiree's retirement and has continued to be covered under that plan (or continuous coverage under subsequent employer group health care plans without a break in coverage) until the date of the Dependent Spouse's retirement;

2. Evidence of Eligibility for the Spouse is provided to the Plan Administrator upon application for reinstatement; and

3. The Board of Trustees approves the reinstatement.

2.13.3. Applicable Rates for Coverage

A. The cost of Retiree coverage is established by the Board of Trustees and is subject to change by them at any time.

B. The cost of Retiree coverage as established by the Trustees will be discounted according to the following schedule.

For all recorded periods of employment in the industry, Retirees will be granted the greater of:

1. Months of credit equal to the total number of months of continuous coverage in the Plan (according to the Plan's computer data); or

2. Months of credit equal to the actual months of coverage in the Plan from April 1982 through the date of determination (according to the Plan's available data).

2.13.4. Calculation of Months of Employment in the Industry

For periods of employment in the industry prior to April 1982, Retirees will be granted twelve (12) months of credit for employment in the industry for each full year of service earned in the National Electrical Benefit Fund on or after March 1, 1963, according to relevant and verifiable data provided by the Retiree.

For periods of employment in the industry after April 1982, the Retiree will be granted credit for a year of employment in the industry for each twelve (12) actual months of coverage under this Family Health Plan. Employees with six (6) or more months of credit remaining after this calculation is performed will be awarded an additional year of employment in the industry. All lesser remainders will be rounded down.

Periods of Military Service followed by reemployment in accordance with the provisions of USERRA will be considered periods of employment in the industry.

No duplicate credit for the same period of time will be provided.

The Plan's determination of months and years of employment in the industry will be final.

2.13.5. Calculation of the Retiree Discount

Retirees with more than ten (10) full years of employment in the industry will receive a discount of one percent (1%) of the cost of Retiree coverage for each credited year of employment in the industry. The Plan will be obligated to cover the cost of any portion of such discount that is attributable to a Retiree's period(s) of Military Service.

EXAMPLE

JOE RETIRED IN SEPTEMBER 2020. IMMEDIATELY PRIOR TO RETIRING, HE HAD BEEN CONTINUOUSLY COVERED UNDER THE PLAN FOR 126 CONSECUTIVE MONTHS. USING THE ROUNDING RULES DESCRIBED ABOVE, JOE WOULD BE CREDITED WITH ELEVEN (11) YEARS OF EMPLOYMENT IN THE INDUSTRY, AND THEREFORE WOULD BE ENTITLED TO THE RETIREE DISCOUNT DESCRIBED IN THIS SECTION.

JIM RETIRED IN SEPTEMBER 2012. ACCORDING TO THE PLAN'S COMPUTER DATA, JIM HAD BEEN COVERED UNDER THE PLAN FOR SIXTY-THREE (63) BENEFIT MONTHS (NON-CONSECUTIVE) SINCE 1982. JIM HAS ALSO PROVIDED DATA TO SHOW THAT PRIOR TO AUGUST 1977, JIM EARNED SIX (6) YEARS OF SERVICE IN THE NATIONAL ELECTRICAL BENEFIT FUND. THIS NEBF SERVICE CONVERTS TO SEVENTY-TWO (72) MONTHS OF CREDIT. COMBINED, JIM IS CREDITED WITH 135 BENEFIT MONTHS. AGAIN, USING THE ROUNDING RULES DESCRIBED ABOVE, THIS IS ROUNDED DOWN TO ELEVEN (11) YEARS. JIM WILL BE ELIGIBLE FOR A RETIREE DISCOUNT BASED UPON THAT TOTAL OF ELEVEN (11) YEARS.

2.13.6. Coverage for Retirees Returning to Work

A. The Plan will provide active coverage (i.e. will be the primary payer) to Retirees who return to work with a Contributing Employer and earn sufficient Premium Credits for that coverage. This coverage will be applied in the applicable Benefit Months as discussed in the Section of this booklet entitled "Initial Eligibility for Bargaining Unit Employees (Other than L.E.A. Employees)."

B. An Employee who retires will be allowed to exhaust the existing Premium Credits in his or her Premium Credit Account for use in obtaining Retiree coverage under the Plan only once during his or her life.

C. Premium Credits earned by a Retiree who returns to work with a Contributing Employer but does not earn enough Premium Credits to achieve active coverage will be added to the Retiree's Premium Credit Account, where they will be applied under existing Plan rules.

D. The retirement premium subsidy available under the Plan will be computed at the time the Retiree originally retires and will not be re-computed unless the Retiree returns to work for a Contributing Employer and gains twenty-four (24) months of coverage. The retirement premium subsidy will then be re-computed after each instance in which the Retiree earns twenty-four (24) months of coverage under the Plan.

2.14. CONTINUATION COVERAGE UNDER COBRA

The Weekly Income Disability Benefit and the Life Benefit are NOT provided under COBRA Continuation Coverage.

If you lose your job, you can make COBRA Self-Contributions to continue your coverage. Your Dependents can also make COBRA Self-Contributions if their coverage will terminate for certain reasons as explained below.

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), gives you and your covered Dependents the right to be offered an opportunity to make Self-

Contributions for continued health care coverage if coverage is lost for certain reasons. This continued coverage is called "Continuation Coverage." The following is a brief outline of the rules governing Continuation Coverage. If you have any questions about this coverage, call the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a thirty (30) day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees. There may also be other coverage options for you and your family through Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

In general, if you do not enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an eight (8) month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

A. The month after your employment ends; or

B. The month after group health plan coverage based on current employment ends.

If you do not enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage. For more information, see https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit https://www.medicare.gov/medicare-and-you.

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Administrator Contact Information:

South Central Minnesota Electrical Workers' Family Health Plan
Wilson-McShane Corporation
1330 Conway Street, Suite 130
St. Paul, MN 55106
(952) 851-5949 / (800) 535-6373

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You may obtain information about the Health Insurance Marketplace at www.HealthCare.gov or call 1-800-318-2596. This Section of COBRA information will serve as your initial notice of your COBRA Continuation Coverage rights as required by the COBRA Regulations.

Please note additional or alternative coverage (other than COBRA Continuation Coverage) may be available to Retired employees, to Spouses, and to other Dependents. Those types of coverage are described elsewhere in this Eligibility Section.

2.14.1. Qualifying Events

A. You and your covered Dependents are entitled to elect Continuation Coverage and to make COBRA Self-Contributions for Plan coverage for up to eighteen (18) months after coverage terminates if coverage terminates due to one of the following events (called "qualifying events"):

1. A reduction in your hours of employment; or

2. Your loss of employment (which includes retirement), except for termination of employment due to gross misconduct.

B. Continuation Coverage may continue for up to twenty-four (24) months if the qualifying event is as a result of military leave (see Section 2.11 "Military Service").

C. In addition, your covered Dependents are entitled to elect Continuation Coverage and to make COBRA Self-Contributions for the coverage for up to thirty-six (36) months after their coverage terminates if that coverage terminates due to one of the following events (called "qualifying events"):

1. Your divorce or legal separation from your Spouse;

2. A child's failure to meet the definition of a Dependent;

3. Your death; or

4. Your entitlement to Medicare benefits.

D. Dependents include children who are born or become your children (e.g., are adopted by you, are placed with you as a foster child, etc.) after you have become entitled to or elected Continuation Coverage. You must make an independent election for coverage for the new Dependent immediately following the date of birth, adoption, or placement. You should contact the Plan Administrator if you acquire a new Dependent while you are covered, or eligible for coverage, under the Plan's Continuation Coverage provisions.

2.14.2. Notification Responsibilities

A. You, your Spouse (or former Spouse if your divorce or legal separation has already become final) and/or your Dependent child must notify the Administrative Manager if you get divorced or legally separated or if your Dependent child loses Dependent status. The Administrative Manager must be notified within sixty (60) days of the date of the qualifying event or within sixty (60) days of the date coverage for the affected Dependent(s) would terminate, whichever date is later. In providing notice, you and/or your Dependents must provide documentation to support the qualifying event. In case of a divorce, a copy of the divorce decree or similar document evidencing the date of the divorce will be required. In the case of loss of Dependent status, documentation indicating the date Dependent status ended will be required.

B. It is your Employer's responsibility to notify the Administrative Manager of any other qualifying events that could cause loss of coverage within thirty (30) days of the qualifying event. However, to make sure that you are sent notification of your election rights as soon as possible, you and/or your Dependent should also notify the Administrative Manager any time any type of qualifying event occurs.

C. You and/or your Dependents are also responsible for notifying the Administrative Manager within sixty (60) days of the date of a disability determination from the Social Security Administration and within the first eighteen (18) months of Continuation Coverage to be eligible for the additional eleven (11) months of coverage which is available to disabled individuals, as explained in greater detail below. In providing notice, you must provide documentation to support the qualifying event. In the case of a disability extension, you must provide a copy of the Social Security Administration determination of disability status.

D. In response to COVID-19, the Plan adopted temporary rules in response to Department of Labor and Internal Revenue Service guidance providing extended timeframes related to notifying the Administrative Manager of a COBRA qualifying event.

Starting on March 1, 2020, the deadline to notify the Administrative Manager of a COBRA qualifying event was suspended during a "Tolling Period," which ends on the earlier of:

Sixty (60) days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the "Outbreak Period"); or

One (1) year from the date the Qualified Beneficiary was first eligible for relief from a deadline related to notification of the Administrative Manager of a COBRA Continuation Coverage qualifying event. The earliest date that a Qualified Beneficiary was first eligible for relief from a deadline related to notification of the Administrative Manager of a COBRA Continuation Coverage qualifying event was either:

1. March 1, 2020 for a COBRA Continuation Coverage qualifying event occurring on or before March 1, 2020. To be in this window, the last day of the applicable deadline must have been on or after March 1, 2020; or

2. Upon the occurrence of a COBRA Continuation Coverage qualifying event after March 1, 2020, but before March 1, 2021.

The calculation of a Qualified Beneficiary's Tolling Period and relief from deadlines and suspension of certain requirements is fact-specific and is analyzed as to each Qualified

Beneficiary. The Tolling Period may not exceed one (1) year. If a COBRA Continuation Coverage qualifying event occurred prior to March 1, 2020, the number of days by which the Qualified Beneficiary is required to take action after the Tolling Period is shortened by the number of days between the date the Qualified Beneficiary was first required to notify the Administrative Manager of a COBRA Continuation Coverage qualifying event and March 1, 2020 (the "Proration Rule").

2.14.3. Maximum Coverage Period

Eighteen (18) months is the maximum period of time that you (the Employee) and your Eligible Dependents can have Continuation Coverage if the Continuation Coverage is the result of your termination or reduction in hours of employment (although coverage may last up to twenty-four (24) months in case of military leave that began on or after December 10, 2004). For you, this maximum period can only be extended in a disability situation, as described below. For your Eligible Dependents, the maximum period can be extended to twenty-nine (29) months in a disability situation or to thirty-six (36) months if one or more new qualifying events occur while covered under Continuation Coverage. "Disabled" means becoming entitled to benefits under the Social Security Act.

Thirty-six (36) months is the maximum period that your Eligible Dependents can have Continuation Coverage if a qualifying event occurs, other than a termination or reduction in hours of employment. Thirty-six (36) months is also the maximum period of time that your Eligible Dependents can have Continuation Coverage even if one or more new qualifying events occur to the Dependent(s) while covered under Continuation Coverage.

If you or your Eligible Dependent are disabled when you elect this coverage, or become disabled within the first sixty (60) days of this coverage, Continuation Coverage may be extended for a period of up to twenty-nine (29) months.

A. For example, suppose that your death occurs while you are making Self-Contributions for Continuation Coverage because of reduced hours. You and your Dependents have been covered under Continuation Coverage for six (6) months before your death. Since your death is a qualifying event for your Dependents, your Dependent Spouse elects to continue coverage by making Self-Contributions for herself and your Dependent children. Your Spouse is entitled to continue coverage for his/herself and the children for an additional thirty (30) months (the maximum coverage period of thirty-six (36) months minus the six (6) months of Self-Contributions you had already made (36 - 6 = 30)).

B. Then, after your Spouse has continued coverage for an additional fifteen (15) months for his/herself and the children, one of the Dependent children loses Dependent status. This is a qualifying event for the child entitling him or her to make Self-Contributions for Continuation Coverage for him/herself. However, the 36-month maximum coverage period is reduced by the twenty-one (21) months of Continuation Coverage already received (six (6)) months from your Self-Contributions before your death plus fifteen (15) months from your Spouse's Self-Contributions). The child is, therefore, entitled to make Self-Contributions for Continuation Coverage for up to an additional fifteen (15) months (36 - 21 = 15).

C. Another circumstance of extended COBRA Continuation Coverage occurs when the qualifying event is the end of your employment and you become entitled to Medicare benefits less than eighteen (18) months before your qualifying event. COBRA Continuation Coverage for qualified beneficiaries, other than you, lasts until thirty-six (36)

months after the date of your Medicare entitlement. For example, if you became entitled to Medicare eight (8) months before the date on which your employment ended, COBRA Continuation Coverage for your Dependent(s) can last up to thirty-six (36) months after the date of the qualifying event which is Medicare entitlement (the maximum thirty-six (36) months of Continuation Coverage minus eight (8) months of Medicare entitlement before your employment termination).

To take advantage of the rules allowing for extended COBRA Continuation Coverage, you and/or your Dependents must provide evidence supporting the occurrence of the second qualifying event to the Administrative Manager to receive the extended COBRA Continuation Coverage. As mentioned previously, in case of a divorce, a copy of the divorce decree must be provided or in the case of a disability determination, a copy of the Social Security disability determination.

2.14.4. COBRA Self-Contribution Procedures and Rules

A. When the Administrative Manager is notified of a qualifying event, an Election Notice will be sent to you and/or your Dependent(s) who would lose coverage due to the event. The Election Notice tells you about your right to elect Continuation Coverage, the due dates, the benefit options that can be elected, the amount of the monthly COBRA Self-Contribution for each option, and other important information.

B. An Election Form will be sent along with the Election Notice. The Election Form is the form you or your Dependent(s) must complete and send back to the Administrative Manager in order to elect Continuation Coverage.

C. The individual electing Continuation Coverage has sixty (60) days after the Plan has sent the Election Notice or sixty (60) days after the coverage would terminate, whichever is later, to elect Continuation Coverage. (However, it is strongly recommended that you send back the completed Election Form as soon as possible.) An election of COBRA Continuation Coverage is considered to be made on the date the Election Form is postmarked.

In response to COVID-19, the Plan adopted temporary rules in response to Department of Labor and Internal Revenue Service guidance providing extended timeframes related to electing COBRA continuation coverage.

Starting on March 1, 2020, the deadline for a Qualified Beneficiary to elect COBRA Continuation Coverage was suspended during a "Tolling Period," which ends on the earlier of:

Sixty (60) days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the "Outbreak Period"); or

One (1) year from the date the Qualified Beneficiary was first eligible for relief from a deadline to elect COBRA Continuation Coverage. The earliest date that a Qualified Beneficiary was first eligible for relief from a deadline to elect COBRA Continuation Coverage was either:

1. March 1, 2020 for COBRA Continuation Coverage election triggering events occurring on or before March 1, 2020. To be in this window, the last day of the applicable deadline must have been on or after March 1, 2020; or

2. Upon the occurrence of a COBRA Continuation Coverage election triggering event after March 1, 2020, but before March 1, 2021.

The calculation of a Qualified Beneficiary's Tolling Period and relief from deadlines and suspension of certain requirements is fact-specific and is analyzed as to each Qualified Beneficiary. The Tolling Period may not exceed one (1) year. If the COBRA Continuation Coverage election triggering event occurred prior to March 1, 2020, the number of days by which a Qualified Beneficiary is required to take action after the Tolling Period is shortened by the number of days between the COBRA Continuation Coverage election triggering event and March 1, 2020 (the "Proration Rule").

A Qualified Beneficiary may elect COBRA Continuation Coverage up until sixty (60) days after the end of the Tolling Period, subject to the Proration Rule. The Plan must still provide a Qualified Beneficiary with COBRA Continuation Coverage election notices within the normal timeframe.

Under the Proration Rule, if a COBRA Continuation Coverage election triggering event occurred prior to March 1, 2020, the extension periods are shortened by the number of days between the event and March 1, 2020.

D. If the completed Continuation Election form is not mailed to the Administrative Manager and postmarked within the sixty (60) day election period, you and/or your Dependents will be considered to have waived your right to Continuation Coverage.

E. An individual electing Continuation Coverage has forty-five (45) days after Continuation Coverage is elected to make his or her initial COBRA Self-Contribution payment. (However, it is strongly recommended that the payment be made as soon as possible so that a number of months will not have to be paid for all at once.) The initial payment must be sufficient to pay all current and past due COBRA Self-Contributions.

Starting on March 1, 2020, the deadline to make the first COBRA Continuation Coverage payment was suspended during a "Tolling Period" which ends on the earlier of:

Sixty (60) days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the "Outbreak Period"); or

One (1) year from the date the Qualified Beneficiary was first eligible for relief from the deadline to make the first COBRA Continuation Coverage payment. The earliest date that a Qualified Beneficiary was first eligible for relief from a deadline related to making the first COBRA Continuation Coverage payment was either:

1. March 1, 2020 for COBRA Continuation Coverage payment grace periods ending on or before March 1, 2020. To be in this window, the last day of the grace period must have been on or after March 1, 2020; or

2. The last date of a COBRA Continuation Coverage payment grace period after March 1, 2020, but before March 1, 2021.

The calculation of a Qualified Beneficiary's Tolling Period and relief from deadlines and suspension of certain requirements is fact specific and is analyzed as to each Qualified Beneficiary. The Tolling Period may not exceed one (1) year. If the COBRA Continuation Coverage payment grace period began but did not end prior to March 1, 2020, the number

of days by which a COBRA Continuation Coverage payment grace period ends after the Tolling Period is shortened by the number of days by which the payment due date preceded March 1, 2020 (the "Proration Rule").

F. Continuation Coverage Self-Contributions must be made monthly. After the initial COBRA Self-Contribution, each subsequent monthly COBRA Self-Contribution is due by the first day of the Benefit Month for which the COBRA Self-Contribution is being made (the "due date"). A COBRA Self-Contribution will be considered on time if it is received by the Plan Administrator within thirty (30) days of the due date.

G. If a COBRA Self-Contribution is not made within the time allowed, Continuation Coverage for you and your Dependents will terminate. The COBRA Self-Contribution may not be made up nor may Continuation Coverage be reinstated by making future COBRA Self-Contributions.

H. You and each of your Dependents who would lose coverage because of a qualifying event are entitled to make a separate election of Continuation Coverage.

I. If you elect Continuation Coverage for yourself and your Dependents, your election is binding on your Dependents unless they make a separate election.

J. An election on behalf of your minor child can be made by you or another parent or legal guardian.

K. The amount of the monthly COBRA Self-Contribution is determined by the Trustees based on federal regulations. The amounts are subject to change, but usually not more often than once a year unless substantial changes are made in the Plan's benefits.

2.14.5. Termination of Continuation Coverage

Continuation Coverage for an individual will terminate at the end of the maximum coverage period or, if earlier, when the first of the following events occurs:

A. A correct and on-time COBRA Self-Contribution is not made to the Plan;

B. The Plan no longer provides group health coverage to any Employees;

C. After the COBRA Continuation Coverage election date, the individual becomes covered under another group health plan which does not contain a pre-existing condition exclusion or limitation applicable to the individual; or

D. After the COBRA Continuation Coverage election date, the individual becomes covered by Medicare.

2.14.6. Proof of Insurability Not Necessary

You do not have to show that you or your Dependents are insurable in order to be entitled to Continuation Coverage unless the Plan would otherwise require that proof from you in order to extend coverage.

2.14.7. If You Have Questions

Questions concerning the Plan or your Continuation Coverage rights should be addressed to the Administrative Manager. For more information about your COBRA rights contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA website at www.dol.gov/agencies/ebsa.

2.14.8. Temporary Waiver of COBRA Continuation Coverage Self-Payments

An Assistance Eligible Individual is not required to make any required Self-Contributions for COBRA Continuation Coverage for any period of coverage during the period from April 1, 2021 through September 30, 2021 (the "Subsidy Period") and is treated as having made such Self-Contributions for all purposes.

An Assistance Eligible Individual is not eligible for relief from the requirement to make Self-Contributions for COBRA Continuation Coverage during the Subsidy Period for any month of coverage that begins on or after the earlier of:

A. The first date that the Assistance Eligible Individual is eligible for coverage under any other group health plan (other than a group health plan that consists of only excepted benefits, a flexible spending arrangement, or a qualified small employer health reimbursement arrangement) or Medicare; or

B. The date following the expiration of the Assistance Eligible Individual's maximum period of COBRA Continuation Coverage.

For periods of COBRA Continuation Coverage following the Subsidy Period, Assistance Eligible Individuals who remain eligible for and continue COBRA Continuation Coverage must make the applicable required Self-Contribution in accordance with the Plan's regular COBRA Self-Contribution rules.

2.14.9. Temporary Extension of COBRA Election Period

Any individual who, as of April 1, 2021, would be an Assistance Eligible Individual except for the fact that he or she does not have a COBRA Continuation Coverage election in effect or has discontinued COBRA Continuation Coverage before April 1, 2021 prior to the expiration of his or her initial COBRA Continuation Coverage period, is eligible to elect (or re-elect, as the case may be) COBRA Continuation Coverage during the period from April 1, 2021 through the date that is 60 days after the date that the Plan Administrator provides the individual with the notice required by Section 2.14.10.

If a qualified beneficiary elects (or re-elects) COBRA Continuation Coverage pursuant to the extended election period described in this Section 2.14.9, such COBRA Continuation Coverage will become effective on the first date of the coverage period that begins on or after April 1, 2021, but such COBRA Continuation Coverage will not extend beyond the last date that such Assistance Eligible Individual would have been eligible for COBRA Continuation Coverage in the absence of the temporary extended election period described in this Section 2.14.9.

2.14.10. Notice to Assistance Eligible Individuals

The Plan Administrator is required to provide Assistance Eligible Individuals and individuals described in Section 2.14.9 who became entitled to elect COBRA Continuation Coverage before

April 1, 2021 with notice of the availability of and information about COBRA Continuation Coverage Self-Contribution assistance, along with the forms required to establish eligibility for Self-Contribution assistance, no later than 60 days after April 1, 2021.

2.14.11. Requirement to Report Notice of Eligibility for Another Group Health Plan or Medicare

Any Assistance Eligible Individual who becomes ineligible for the temporary waiver of the requirement to make COBRA Continuation Coverage Self-Contributions during the Subsidy Period under Section 2.14.8(A), due to eligibility for another group health plan or Medicare, must notify the Plan in accordance with rules established by the Plan Administrator.

2.14.12. Assistance Eligible Individual

An Assistance Eligible Individual is, with respect to any period of COBRA Continuation Coverage during the period beginning on April 1, 2021 and ending on September 30, 2021, a COBRA qualified beneficiary who elects COBRA Continuation Coverage and became eligible for COBRA Continuation Coverage due to a loss of coverage resulting from either the Employee's termination of employment (other than the Employee's voluntary termination of employment or involuntary termination of employment due to the Employee's gross misconduct) or a reduction in the Employee's hours of employment.

2.15. HIPAA SPECIAL ENROLLMENT EVENTS

An Employee, or his or her Dependent, is entitled to special enrollment rights under the Plan as required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") under either of the following circumstances:

A. The Employee's or Dependent's coverage under a Medicaid plan or under a state children's health insurance program is terminated as a result of eligibility for such coverage and the Employee requests coverage under the Plan not later than sixty (60) days after the date of termination of such coverage.

B. The Employee or Dependent becomes eligible for a state premium assistance subsidy from a Medicaid plan or through a state children's health insurance program with respect to coverage under the Plan and the Employee requests coverage under the Plan not later than sixty (60) days after the date the Employee or Dependent is determined to be eligible for such assistance.

C. In response to COVID-19, the Plan adopted temporary rules in response to Department of Labor and Internal Revenue Service guidance providing extended timeframes related to special enrollment periods.

Starting on March 1, 2020, the deadline to notify the Administrative Manager of a special enrollment period was suspended during a "Tolling Period" which ends on the earlier of:

Sixty (60) days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the "Outbreak Period"); or

One (1) year from the date the Eligible Individual was first eligible for relief from a deadline to notify the Administrative Manager of a special enrollment period. The earliest date that

an Eligible Individual was first eligible for relief from a deadline to notify the Administrative Manager of a special enrollment period was either:

1. March 1, 2020 for special enrollment events occurring on or before March 1, 2020. To be in this window, the last day of the applicable deadline must have been on or after March 1, 2020; or

2. Upon for special enrollment events occurring on or before March 1, 2020. To be in this window, the last day of the applicable deadline must have been on or after March 1, 2020; or

The calculation of an Eligible Individual's Tolling Period and relief from deadlines and suspension of certain requirements is fact-specific and is analyzed as to each Qualified Beneficiary. The Tolling Period may not exceed one (1) year. If the special enrollment event occurred prior to March 1, 2020, the number of days by which an Eligible Individual is required to take action after the Tolling Period is shortened by the number of days between the trigger event date and March 1, 2020 (the "Proration Rule").

An Eligible Individual's obligation to notify the Plan of a special enrollment event is extended to sixty (60) days after the end of the Tolling Period, subject to the Proration Rule.

2.16. OPT-OUT FOR MAJOR MEDICAL EXPENSE BENEFIT AND PRESCRIPTION DRUG BENEFITS

An Eligible Employee who satisfies the eligibility requirements of Subsections 2.2 and 2.3 above by maintaining the required Premium Credits may elect to opt-out of Major Medical Expense Benefit coverage, including Preferred Provider Pharmacy Prescription Drug Benefits, under this Plan if the Eligible Employee is eligible to enroll in a health plan offered by his or her Spouse's employer, or in a government-sponsored health plan. An election to opt-out of Major Medical Expense Benefit coverage, including Preferred Provider Pharmacy Prescription Drug Benefits, is effective for the Eligible Employee and all of his or her Eligible Dependents.

The Eligible Employee must complete an "Application to Waive Coverage for Major Medical Benefits in Favor of Other Available Coverage" form to opt-out of coverage under the Plan. This Application can be obtained from the Administrative Manager The Eligible Employee must indicate the date upon which the waiver of coverage will be effective and certify that he or she will be enrolled in a health plan offered by his or her Spouse's employer on the effective date. All Applications are subject to approval by the Plan. An Eligible Employee whose coverage has been terminated but who subsequently becomes eligible for coverage under the Plan must submit a new Application form to opt-out of coverage again under this Section.

The following conditions apply to the Eligible Employee and all of his or her Dependents during the time that an election to opt-out of Major Medical Expense Benefit coverage, including Preferred Provider Pharmacy Prescription Drug Benefits, is in effect:

A. The Eligible Employee and all of his or her Eligible Dependents will not be entitled to any Major Medical Expense Benefits, including Preferred Provider Pharmacy Prescription Drug Benefits, under this Plan or payment from the Plan for such benefits.

B. The Eligible Employee and all of his or her Eligible Dependents forfeits any right to Major Medical Expense Benefits, including Preferred Provider Pharmacy Prescription Drug

Benefits, under the Plan even if those Plan benefits are superior in some respects to the benefits under the plan offered by the Eligible Employee's Spouse's employer.

C. The Eligible Employee will continue to be enrolled in the Life Benefit and Weekly Income Disability Benefit under the Plan and will continue to be eligible for the Plan's Premium Credit Account Reimbursement Program.

D. The election to opt-out of Major Medical Expense Benefit coverage, including Preferred Provider Pharmacy Prescription Drug Benefits, will not affect the Eligible Employee's accrual of eligibility for Retiree Benefits.

E. The Plan will charge the Eligible Employee's Premium Credit Account a premium, set by the Trustees from time to time, for continued eligibility for Life Benefits, Weekly Income Disability Benefits, and Retiree Benefits. If an Eligible Employee's Premium Credit Account is not sufficient, the Eligible Employee will be required to make self-payments to continue these benefits. If an Eligible Employee does not maintain these benefits, the Eligible Employee and his or her Dependents must satisfy the initial eligibility rules to return to coverage under the Plan.

F. The Eligible Employee and his or her Eligible Dependents may only return to coverage under the Plan if:

1. The Eligible Employee (1) applies in writing to return to Plan coverage during the Plan's annual open-enrollment period (which is December 1–31 each year), and (2) the Eligible Employee and his or her Eligible Dependents otherwise meet the eligibility requirements of the Plan;

2. The Eligible Employee or an Eligible Dependent loses coverage under the health plan offered by the Eligible Employee's Spouse's employer and (1) the Eligible Employee applies in writing to return to Plan coverage within 31 days after the loss of coverage under the plan offered by the Eligible Employee's Spouse's employer, and (2) the Eligible Employee and his or her Eligible Dependents otherwise meet the eligibility requirements of the Plan; or

3. The Eligible Employee's coverage is terminated and the Eligible Employee subsequently becomes re-eligible for coverage under the Plan pursuant to the Initial Eligibility Rules (Sections 2.2 and 2.3 above). The Eligible Employee will automatically be Covered Under the Plan.

G. The Trustees reserve the right to discontinue all waivers at any time and require all Eligible Employees to immediately re-enroll in the Plan.

2.17. ENROLLMENT, RE-ENROLLMENT, AND PROVIDING INFORMATION

The Plan may require that Eligible Employees, Eligible Retirees, and their Dependents who wish to be covered by the Plan enroll by providing information to the Plan in a form satisfactory to the Plan. Enrollment includes periodic re-enrollment, as the Plan may require, and also providing information from time to time per the Plan's request. The information may include personal data (including, but not limited to, Social Security numbers) the Plan needs to be able to process claims for benefits and to allow the Plan to comply with governmental reporting requirements. The Plan takes precautions to protect personal information and does not ask for information not needed for its legitimate purposes. Failure to enroll, re-enroll, or provide requested information may result in

suspension and/or loss of Plan coverage. (See Section 18 of this booklet ("Termination of Benefits.")

2.18. ELIGIBILITY FOR HELPERS/PRE-APPRENTICES

A Helper/Pre-Apprentice will be eligible to participate in the Plan under the same terms and conditions as Bargaining Unit Employees, as provided in this Eligibility Section.

Benefits will begin as provided in Section 2.2. However, participation will not begin unless and until the Employer has notified the Plan of the Helper's/Pre-Apprentice's employment as a Helper/Pre-Apprentice and the Employer has paid the required contribution to the Plan.

SECTION 3 SCHEDULE OF BENEFITS

SUMMARY

This Schedule of Benefits provides you with a brief description of the benefits provided under this Plan as well as limitations that apply to each type of benefit. Benefits are payable to Eligible Employees (and their Eligible Dependents) only for services described in this booklet that are Medically Necessary and not otherwise excluded (see, for example, the "Plan Conditions, Limitations and Exclusions"). More information about these benefits is provided in the later Sections of this booklet. See the Table of Contents for the location of these later Sections.

This Schedule of Benefits describes the maximum amount payable by the Plan for any benefit. Of course, the amount payable may be affected by the other provisions of this Plan, including the limitations provisions and the description of the specific benefits payable under the Plan contained in each Section.

**Please note that effective May 1, 2022, certain out-of-network services will be treated as in-network services for cost sharing purposes pursuant to the No Surprises Act. Payments for such out-of-network services will be counted toward in-network deductibles and in-network maximum out-of-pocket limits (except for copayments, which do not count toward deductibles or maximum out-of-pocket limits, as noted below). Please see the "No Surprises Act" topic in Section 8 below for important information regarding coverage of certain out-of-network items and services as in-network items and services effective May 1, 2022.*

3.1. COVERED MEDICAL EXPENSES

- Hospital Services and Supplies
- Transportation Services
- Inpatient Physician's Expense
- Surgical Expense
- Reconstructive Surgery
- Prophylactic Mastectomy
- Bariatric Surgery
- Diagnostic X-Rays
- Laboratory Examinations
- Maternity Expenses
- Preventative Care
- Immunizations
- Health Club Discount
- Hospice Care
- Home Nursing Care
- Skilled Nursing Facility Care
- Prescription Drugs
- Genetic Testing
- Organ and Tissue Replacement
- Dental and Oral Surgical Services
- Hearing Health Care Services Discount
- Telemedicine Services

Additional information about each of these services can be found in Section 8 of this document ("Covered Medical Expenses").

3.2. CALENDAR YEAR MAXIMUM BENEFIT LIMITS

Certain benefits provided under the Plan are subject to Calendar Year maximum limits, as follows:

- Chiropractic Care (per Eligible Individual): $500

3.3. DEDUCTIBLE PER CALENDAR YEAR

A. Employee: $350

B. Family: $700

Please note: Copayments do not apply towards satisfaction of the Deductible.

3.4. COINSURANCE

80% / 20% coverage of Reasonable and Customary Covered Expenses, subject to the following Calendar Year maximum out-of-pocket Coinsurance amount:

A. Per Eligible Individual: $2,000

B. Family Maximum: $4,000

Each Eligible Individual will pay twenty percent (20%) of any Reasonable and Customary Covered Expense in excess of the applicable Copayments and Deductible, subject to the maximum out-of-pocket Coinsurance expense, before the Plan will begin to pay benefits. After the Calendar Year maximum out-of-pocket Coinsurance amount (exclusive of Copayments and Deductible amounts) is reached, the Plan will pay 100% of any Reasonable and Customary Covered Expenses for the remainder of that Calendar Year.

However, Coinsurance for Prescription Drugs will not be included in the maximum out-of-pocket expense.

3.5. COPAYMENTS

Copayments are fixed dollar amounts Eligible Individuals must pay before receiving certain Covered Services such as urgent care, Physician office visits and prescriptions.

Please note: *Copayments do not apply towards satisfaction of the Deductible or Maximum out-of-pocket Coinsurance amounts.*

A. Applicable Copayments for various Covered Medical Expenses are as follows:

1. Office Visits: $40
2. Urgent Care Center: $40
3. Convenience Care Clinic: $10
4. Telemedicine Services: $0
5. Preventative Medicine: $0
6. Emergency Care: $115

7.	Outpatient Hospital (Emergency Room):	$115
8.	Emergency Room Physician Charges:	$115
9.	All other Emergency Room Charges:	$115
10.	Hospital Services (Room & Board):	$50 (semi-private max)
11.	Chiropractic Care:	$40
12.	Physical Therapy:	$40*
13.	Speech Therapy:	$40*
14.	Occupational Therapy:	$40*
15.	Mental Health (Inpatient):	$50
16.	Mental Health (Outpatient):	$40
17.	Chemical Dependency (Inpatient):	$50
18.	Chemical Dependency (Outpatient):	$40
19.	Prescription Drugs:	See Section 1.7

***Please Note:** *Pre-authorization is required when more than twenty-five (25) sessions of physical therapy, speech therapy, or occupational therapy per episode of care are recommended.*

B. The following benefits have no Copayment, but are subject to the Deductible and Coinsurance:

1. Inpatient Physician Calls and Inpatient Surgery.

2. Scheduled Outpatient Services including Outpatient Surgery Hospital & Physician, Surgery Charges.

3. X-Ray and Lab Work.

4. Miscellaneous Services: Durable medical equipment, skilled nursing facility, home health care, ambulance.

5. Private duty nursing, non-durable medical equipment, prosthetics, accidental dental.

6. Dental – impacted teeth removal and related charges only.

C. Certain expenses covered under the Preventative Medicine Program are not subject to the Deductible or a Copayment, but are subject to Coinsurance and limitations, as follows:

1. Well baby care

a. Coverage is only applicable for Dependent children.

2. Immunizations

   a. Coverage for immunizations is limited to those recommended by the Department of Health and Human Services Centers for Disease Control and Prevention for the Eligible Individual.

3. Pap Smears and mammograms

4. Routine Physical Examinations

   a. One examination every Calendar Year.
   b. Coverage is only applicable for an Eligible Employee and the Eligible Employee's Spouse.

5. Prostate Specific Antigen (PSA) Test Benefit

   a. One procedure is covered per Calendar Year. An additional procedure may be covered if there is a Medical Necessity.
   b. Coverage is only applicable to male Eligible Individuals forty (40) years of age and older.

6. Colonoscopy Benefit

   a. Coverage is applicable if there is a Medical Necessity.

3.6. PRESCRIPTION DRUG BENEFITS

Please note: *Copayments for prescription drugs do not count towards reaching the annual maximum out-of-pocket Coinsurance expense limit for major medical benefits.*

3.6.1. Outpatient Prescription Drugs & Diabetic Supplies

A. *Generic Drugs* - Copayment of 20% of the Covered Expenses for the prescription drugs, with a minimum Copayment of $10.00 and a maximum Copayment of $75.00 per prescription fill.

B. *Brand Name Drugs* - Copayment of 20% of the Covered Expenses for the prescription drugs, with a minimum Copayment of $15.00 and a maximum Copayment of $75.00 per prescription fill.

This drug benefit is offered through CVS Caremark. Please Call the Administrative Manager at 800-535-6373 for further information.

The Plan has a Utilization Management Program ("UMP"). Under the UMP, prescription drugs may be subject to prior authorization, step therapy, and quantity limit requirements.

3.6.2. Specialty Drug Program

All specialty drug prescriptions must be obtained through the CVS Caremark Specialty Pharmacy. Specialty prescription drugs may be subject to prior authorization, step therapy, and quantity limit requirements. If your Physician recommends prescription quantities that exceed the quantity limits, your Physician will need to submit a prior authorization ("PA") request to CVS Caremark

that includes the medical reasons supporting the request. Your Physician can visit caremark.com to download the PA form.

A. Specialty Coupon Assistance Program.

Under the Plan's Specialty Drug Coupon Program, certain brand medications may be subject to a higher copayment that, net of an available pharmaceutical coupon/assistance applied by PrudentRx, will yield a net participant copayment at the time of service of $0 for medications filled through the PrudentRx program.

3.7. OTHER COVERAGE EXCLUSIONS OR LIMITATIONS

The following expenses are excluded from coverage under the Plan, or otherwise limited as follows:

A. Birth Control:

1. Coverage provided for voluntary vasectomies and other sterilization procedures.
2. No coverage for prescription medication unless Medically Necessary and prescribed by a Physician.

B. Infertility Treatment:

1. Coverage provided for diagnostic work-ups and follow-ups.

2. No coverage for hormone therapy, artificial insemination, or any other direct attempt to induce or facilitate fertility or conception.

C. Reversal of voluntary sterilization.

D. Voluntary Abortion:

1. Covered only if life or health of mother or fetus is threatened, or pregnancy is the result of an assault or incest.

E. Hearing Aids/Hearing Assistance Devices:

1. Covered provided a Physician deems the devices Medically Necessary to correct a congenital defect which has resulted in a functional deficit.

F. Cosmetic or plastic surgery.

G. Physical exams for employment or insurance purposes.

H. Health services that are Experimental or Investigational.

I. Custodial or "rest cures."

J. Surgery and care associated with morbid obesity:

1. No Coverage, except as provided in Section 8 ("Covered Medical Expenses") of this booklet and subject to the Plan's other coverage rules.

3.8. LIFE & WEEKLY DISABILITY BENEFITS

A.	Life Benefit	$5,000
B.	Weekly Income Disability Benefits:	
	Maximum Loss-of-Time Benefit/Weekly Disability Rate:	$600
	Maximum Benefit Period:	52 Weeks
	Waiting Period for Disability:	
	Due to Injury:	7 Days
	Due to Illness:	7 Days

*****LIFE BENEFIT AND WEEKLY DISABILITY INCOME BENEFITS ARE PAYABLE ONLY TO BARGAINING AND NON-BARGAINING UNIT EMPLOYEES*****

SECTION 4 EFFECTIVE DATE OF BENEFITS

SUMMARY

This Section of the booklet describes how you and your Dependents become eligible for benefits under the Plan, and the various ways you can maintain that eligibility.

Once you become eligible, you will continue to be covered if you satisfy the requirements of the Plan as described more fully in this Section.

ALL EMPLOYEES MUST COMPLETE AND RETURN AN ENROLLMENT FORM TO THE ADMINISTRATIVE MANAGER BEFORE THE PLAN CAN CONSIDER CLAIMS FOR BENEFITS.

4.1. EMPLOYEES

An Employee's benefits will become effective on the date specified under the applicable initial eligibility rules in the Section of this booklet entitled "Eligibility." This date is known as the Initial Eligibility Date.

4.2. DEPENDENTS

The Effective Date of coverage for an Employee's Dependent's is one of the following dates:

A. For each individual who is a Dependent on the Employee's Initial Eligibility Date, coverage will be effective on the same day as the Employee's Initial Eligibility Date provided that:

1. The Dependent is not Hospital confined due to a non-occupational Sickness or Injury; and

2. The Employee files an updated Enrollment form on behalf of the Dependent with the Plan Administrator within thirty-one (31) days of the Employee's Initial Eligibility Date.

B. For each individual who becomes a Dependent after the Employee's Initial Eligibility Date, coverage will be effective on the day that the individual satisfies the definition of Dependent provided that:

1. The Dependent is not Hospital confined due to a non-occupational Sickness or Injury; and

2. The Employee files an updated Enrollment form on behalf of the Dependent with the Plan Administrator within thirty-one (31) days of the date the individual satisfies the definition of Dependent.

C. If a Dependent is Hospital confined due to non-occupational Sickness or Injury on the date the Dependent's benefits would have otherwise been effective, on the date that the Dependent is no longer Hospital confined.

D. Coverage for a newborn Dependent child will take effect on the date of birth whether or not the child is Hospital confined on account of Sickness or Injury provided that you, the Eligible Employee, have Dependent coverage at the time of the child's birth.

E. If you, the Eligible Employee, do not have Dependent Coverage at the time of the child's birth, coverage for the newborn Dependent child will take effect on the date of birth whether or not the child is Hospital confined on account of Sickness or Injury provided that you, the Eligible Employee files an updated Enrollment form within thirty-one (31) days of the birth.

F. If an Employee files an Enrollment form after the thirty-one (31) day period discussed above or after termination of coverage due to failure to make required Self-Contributions, the Eligible Employee must provide an updated Enrollment form to the Administrative Manager for each Dependent. Coverage will be effective on the date that the Administrative Manager approves the application.

SECTION 5 LIFE BENEFIT FOR ELIGIBLE EMPLOYEES ONLY

SUMMARY

The Plan provides a benefit to your designated Beneficiary in the event of your death while you are covered under this portion of the Plan. To designate or change a Beneficiary, contact the Plan Administrator's office.

There are several limitations to the payment of this benefit. They are described in this Section.

A Life Benefit is provided to the Eligible Bargaining Unit Employee's designated Beneficiary subject to the following provisions. Retirees are not eligible for this benefit.

5.1. LIFE BENEFIT

A Life Benefit will be paid in the event an Eligible Employee dies while covered by this benefit. The amount of coverage is set forth in the Schedule of Benefits.

5.2. EXCLUSIONS

No Life Benefit is paid for:

A. Death due to accidents occurring while participating in an Act of War. "Act of War" includes any act or conduct during war, declared or undeclared, act of terrorism, or war-like activity by any individual, government, sovereign group, terrorist, insurrection or other organization.

B. Reserved.

C. Your death resulting from your engaging in an illegal act, as defined in Paragraph (LLL) of the "Plan Conditions, Limitations, and Exclusions" Section of this booklet, unless the illegal act results from a mental or physical health condition of the Eligible Employee, as determined by the Trustees in their sole discretion, based on the information that has been made available to and is within the control of the Trustees at the time of their decision, which may include accident, crime, medical examiner, police, or similar reports or documentation that the Trustees may reasonably require in connection with a Beneficiary or claimant's claim for Life Benefits.

5.3. BENEFICIARY DESIGNATION

At the time of enrollment, you must complete a form naming one (1) or more primary Beneficiaries or alternative Beneficiaries. A Beneficiary designation will not be effective unless the designation includes the name, Social Security number, and address of the Beneficiary, as well as a description of the Beneficiary's relationship to you. If you name two (2) or more individuals as primary Beneficiaries, the benefit will be shared equally by any of them that survive you, unless you specify otherwise. If none of the primary Beneficiaries survive you, the benefit will be shared equally by any alternative Beneficiaries that survive you, unless otherwise specified. You may change any Beneficiary designation from time-to-time without providing notice to any Beneficiary or getting the consent of any Beneficiary.

It is important to keep your Beneficiary information up to date. If, for example, there is a change in your marital status or the birth of a child, you may wish to change your Beneficiary designations to reflect the change. Also keep in mind that a Beneficiary designation becomes immediately ineffective if the indicated legal relationship ends because of a judgment and decree of marital dissolution. For example, the designation of a Beneficiary labeled as your "Spouse" becomes ineffective upon divorce.

5.4. PAYMENT IN THE ABSENCE OF A BENEFICIARY DESIGNATION

The Eligible Employee should designate his or her Beneficiary to receive this Life Benefit on the forms available from the Plan Administrator.

In the event the Eligible Employee has failed to designate a Beneficiary, or if the Beneficiary does not survive the Employee, the Life Benefit will be payable equally to all surviving members per capita of the first of the following classes to survive the Employee:

1. The Employee's Spouse on the date of the Employee's death;
2. The Employee's surviving children, including legally adopted and illegitimate children;
3. The Employee's parents;
4. The Employee's brothers and sisters;
5. The Employee's estate.

Please Note: If you designate a minor child as your Beneficiary, you must provide the Plan Administrator with information regarding the child's guardian or about the trust from which the payment of benefits will be made.

5.5. TAXATION OF LIFE BENEFIT

All Life Benefits paid by the Plan on behalf of Eligible Employees death are taxable income to the individual(s) who receives the benefit.

SECTION 6 WEEKLY INCOME DISABILITY BENEFIT FOR ELIGIBLE EMPLOYEES ONLY

SUMMARY

The Plan provides specific loss-of-time benefits if an Eligible Employee becomes Totally Disabled at a time when he or she is otherwise Covered Under The Plan. The requirements to receive those benefits are set forth in this portion of the document.

If you (the Employee) have been disabled, contact the Plan Administrator to determine if you are eligible for this valuable benefit. This benefit is available only to Eligible Employees. Retirees are not eligible for this benefit.

6.1. ELIGIBILITY FOR BENEFITS

To be eligible for the Weekly Income Disability Benefit, an Employee must meet all of the following requirements:

A. The Employee must be Totally Disabled as a result of a non-occupational accidental bodily Injury or Sickness and be completely unable to perform each and every duty of his or her occupation or employment. For purposes of this disability benefit, an Employee will be considered Totally Disabled if they are disabled due to organ or tissue donation.

B. The Employee must be Covered Under The Plan on the date the Total Disability began.

C. The Employee must be under the care of a Physician for the Total Disability.

D. The Employee must provide medical proof of the Total Disability certified by a Physician that is satisfactory to the Plan.

E. The Employee must satisfy the 7-day Waiting Period noted in the Schedule of Benefits.

F. The Employee must, as required by the Plan from time-to-time, submit to an examination by a Physician of the Plan's choosing (and at the Plan's expense) to confirm the Total Disability.

Please refer to the Schedule of Benefits for additional information regarding the classes of employees eligible for this benefit.

6.2. AMOUNT OF BENEFITS PAID

The benefit amount is the weekly rate of benefits shown in the Schedule of Benefits and will begin on the eighth (8^{th}) day of Total Disability.

The benefit is paid on the basis of a 7-day work week. If benefits are due for a fractional part of a week, the Employee will receive 1/7 of the weekly benefit for each day of Total Disability. Benefits will be reduced by the amount of FICA taxes (Social Security) required to be withheld.

6.3. CONTINUATION OF BENEFITS

After payment of the Weekly Income Disability Benefit for a continuous period of fifty-two (52) weeks, the Plan may in the Trustee's discretion continue to periodically pay the Weekly Income Disability Benefit while the Employee is unable to engage in any paid occupation or employment

for which the Employee, through education and training, including rehabilitative training, is or may become reasonably qualified.

6.4. SUCCESSIVE PERIODS OF DISABILITY

If the Employee becomes Totally Disabled two (2) or more times for the same or related condition, and if each disability is separated by less than two (2) weeks of active work, they may be considered as one period of disability. For example, if you were receiving Weekly Income Disability Benefits for a condition or conditions from which you recovered and returned to work for less than two (2) weeks. However, after returning to work, you became Totally Disabled again as a result of the same condition(s) contributing to your need for the prior period of disability. The second period of disability would be considered a continuation of the first one for benefit purposes. This means that no Waiting Period is required.

If the two (2) periods of disability result from different causes and the Employee has returned to active work for one full day, the second disability will be a new period of disability. Assume that you returned to work for two (2) weeks or less and became disabled for a different reason from the one causing your earlier disability. The second disability is considered separate from the first one for benefit purposes.

6.5. EXCLUSIONS AND LIMITATIONS

No Weekly Income Disability Benefits will be paid for any disability which results from:

A. Any Injury or Sickness for which the Employee is not under the direct and continuing care of a Physician;

B. Any Injury which occurred while working under any occupation or employment for wage or profit;

C. Any Injury or Sickness due to intentionally self-inflicted Injury unless the self-inflicted injury results from the physical or mental health condition of the Eligible Employee;

D. Any Injury or Sickness for which the Employee is or may be entitled to receive benefits in whole or in part under No-Fault Insurance or any Worker's Compensation law, Occupational Diseases law, Employer's Liability law, Unemployment Compensation law, or similar law;

E. For any disability that results from any Injury or Sickness sustained as a result of conduct that would exclude payment of benefits for any loss, expense or charge related to such Injury or Sickness under the Plan pursuant to the Plan Conditions, Limitations and Exclusions Section of this document, or such Injury or Sickness that otherwise would be excluded from coverage pursuant to such Section.

6.6. OTHER INCOME BENEFITS

Monthly benefits will be reduced by the amount of Other Income Benefits, as defined below, available (whether or not claim is made for benefits under the other policy) if the Employee becomes Totally Disabled as a result of an accidental Injury or Sickness or as a result of pregnancy, childbirth, or a related medical condition and remains continuously so disabled. The Employee must be under the care of a duly qualified Physician.

Other Income Benefits include:

A. Any other group policy of accident and health insurance providing benefits for loss-of-time from employment due to disability, and toward the cost of which the Employer will has contributed or with respect to which the Employer has made payroll deductions;

B. Any plan, fund or other arrangement, by whatever name called, providing benefits for loss-of-time from employment because of disability pursuant to any compulsory benefit act or law of any government including, but not limited to, benefits provided under workers' compensation and Social Security;

C. Any reparations act of any government, but only to the extent the reparations for loss of income are provided without regard to fault under that act;

D. Any plan, fund or other arrangement, by whatever name called, towards the cost of which the Employer has contributed or with respect to which the Employer has made payroll deductions, including, but not limited to, any group life policy providing installment payments in event of permanent total disability, any group annuity contract, or any pension or retirement annuity plan. Benefits under any pension or retirement annuity plan, other than disability benefits, will be included as Other Income Benefits only if the Employee has applied for and is in fact receiving those pension or annuity benefits; and

E. Any compensation the Employee receives attributable to work for remuneration.

If the Eligible Employee subsequently receives payment of Other Income Benefits for any period that the Plan paid Weekly Income Disability Benefits, and such payment would have reduced the amount of benefits payable by the Plan if it had been made at the time the Plan paid the benefits, then the Plan is entitled to a first priority right of reimbursement from any payment of Other Income Benefits to or on behalf of the Employee. In exchange for the payment of benefits under this Section 6.6, the Employee must sign a separate Subrogation and Reimbursement Agreement acknowledging the Plan's first priority right of reimbursement from any payment of Other Income Benefits the Employee receives and agreeing to be personally liable if the Employee does not reimburse the Plan as required.

6.7. TAXATION OF WEEKLY INCOME DISABILITY BENEFITS

Weekly Income Disability Benefits are subject to income tax. The Employee will receive a Form 1099-MISC for use in preparing his or her tax return.

In general, Weekly Income Disability Benefits are also subject to Social Security taxes (FICA). The Employee pays half of the tax, and the Plan pays the other half. According to federal laws, the Plan will withhold the Employee's share of the FICA tax from each weekly benefit check paid to you during the first six (6) full months of your disability and will send it to the government. You must include the portion of your Weekly Income Disability Benefits that is subject to FICA in your gross income and pay federal income tax on the benefits.

If, however, you receive Weekly Income Disability Benefits and you made Self-Contributions to continue your benefits, Social Security taxes will not be withheld. In this case, the Weekly Income Disability Benefits are not considered taxable income.

You should contact a competent tax advisor or attorney if you have any questions regarding your Weekly Income Disability Benefits.

SECTION 7 MAJOR MEDICAL EXPENSE BENEFIT

SUMMARY

This Section and the next Section entitled "Covered Medical Expenses" describe most of the benefits payable under the Plan when you or your Eligible Dependents suffer from an Injury or Sickness. When you and your Eligible Dependents incur charges for benefits payable under this Section, an annual deductible will apply. You will also be required to pay the percentage (known as "Coinsurance") of the charges for benefits not covered by the Plan, up to a maximum out-of-pocket amount. Please see below and the Schedule of Benefits for additional details on the level of coverage, including your share of Covered Charges.

Benefits are payable only to Eligible Individuals for the Reasonable and Customary Charges for services described in this booklet that are Medically Necessary and not otherwise excluded from coverage. Each Covered Expense is deemed incurred on the date the supply or service is provided.

If you have questions about the benefits payable under these Sections, please contact the Administrative Manager.

7.1 CALENDAR YEAR DEDUCTIBLES

A. Individual Deductible. Once an Eligible Individual individually incurs Covered Charges that would satisfy the Individual Deductible specified in the Schedule of Benefits, no further Deductible will be required for that Eligible Individual for the remainder of the Calendar Year.

B. Family Deductible. After the Eligible Employee or his or her Eligible Dependent(s) have incurred Covered Charges that would satisfy the Family Deductible specified in the Schedule of Benefits, no further Deductible will be required of the Eligible Employee or his or her Eligible Dependent(s) for the remainder of that Calendar Year.

7.2 DEDUCTIBLE RULES

1. All Deductibles are based on an accumulation period of a Calendar Year (January 1 through December 31 of each year);

2. Only your payments for Covered Medical Expenses will be used to satisfy a Deductible;

3. If an Eligible Individual is suffering from a condition for which Covered Medical Expenses are incurred in two (2) or more years, the Deductible must be satisfied each Calendar Year; and

4. Each Eligible Individual must satisfy the Individual Deductible each Calendar Year, except that once the Family Deductible is satisfied during a Calendar Year, no further Individual Deductibles must be satisfied by any Eligible Individual of that family during that Calendar Year.

7.3 PLAN COPAYMENTS

Eligible individuals will be required to pay a Copayment for certain services and treatment as specified in the Schedule of Benefits, to include, but not limited to, office visits, urgent care visits, Hospital admissions, emergency room visits, etc. The Copayments do not count towards the satisfaction of an Eligible Individual's Calendar Year Deductible or any Coinsurance maximums.

7.4 PLAN BENEFITS PAID (COINSURANCE)

Once the Deductible is satisfied, the Plan pays a certain percentage of the charges for Covered Medical Expenses. The remaining percentage is known as "Coinsurance," which you must pay out-of-pocket until you reach the maximum out-of-pocket expense limit specified on the Schedule of Benefits. You must also pay any expense not considered a Covered Medical Expense.

Please note that this Coinsurance rule does not apply to prescription drug coverage. There is a separate and distinct maximum out-of-pocket expense limit specified in the Schedule of Benefits, which you must satisfy for prescription drug coverage. Coinsurance paid as part of the prescription drug benefits coverage will not count towards satisfaction of the maximum out-of-pocket expense limit for major medical benefits, and Coinsurance paid as part of the major medical benefit coverage will not count towards satisfaction of the maximum out-of-pocket expense limit for prescription drug benefits coverage.

The Plan will generally pay eighty percent (80%) of Covered Charges. You will pay the rest, which includes twenty percent (20%) of the Covered Charges (the "Coinsurance"), expenses that are not Covered Medical Expenses, charges that exceed the Reasonable and Customary Charge, and any Copayments.

7.5 MAXIMUM OUT-OF-POCKET COINSURANCE EXPENSES

The Plan limits the amount you have to pay for Covered Medical Expenses in any Calendar Year. The maximum out-of-pocket Coinsurance expense for each Eligible Individual (excluding Copayments) is the amount paid toward the Individual or Family Deductible plus your Coinsurance share of Covered Medical Expenses. Please see the Schedule of Benefits for the dollar amounts. Once the Deductible and maximum out-of-pocket Coinsurance limits for a Calendar Year are reached, the Plan pays one hundred percent (100%) of Covered Medical Expenses for the remainder of the Calendar Year, excluding applicable Copayments.

Please refer to the examples below for an explanation of how the Plan's Deductible, Copayment, Coinsurance and maximum out-of-pocket limits work.

EXAMPLES

Example 1

You have Covered Charges for a Hospital admission of	$15,000
You pay the Hospital admission Copayment of	- $50
You pay the individual Deductible	- $350
Remaining Charges	**$14,600**
You pay 20% of the first $10,000 in Covered Charges	- $2,000
Remaining Charges	**$12,600**
Plan pays 80% of the first $10,000 in Covered Charges	-$8,000
Remaining Charges	**$4,600**
Plan pays remaining Covered Charges at 100%	-$4,600
Total Remaining Charges	**$0**

The Plan will also pay 100% of your Covered Charges for the remainder of the Calendar Year.

Example 2

Your family of 3 has Covered Charges (including one Hospital admission) of	$25,000
You pay the Hospital admission Copayment of	- $50
You pay the individual Deductibles	- $700
Remaining Charges	**$24,250**
You pay 20% of the first $20,000 in Covered Charges	- $4,000
Remaining Charges	**$20,250**
Plan pays 80% of the first $20,000 in Covered Charges	-$16,000
Remaining Charges	**$250**
Plan pays remaining Covered Charges at 100%	-$250
Total Remaining Charges	**$0**

The Plan will also pay 100% of Covered Charges incurred by you or your Dependents for the remainder of the Calendar Year.

SECTION 8 COVERED MEDICAL EXPENSES

Covered Medical Expenses are the medical charges incurred by an Eligible Individual which are considered for payment under the Major Medical Expense Benefit. The amount payable is subject to the maximum benefits and limitations shown on the Schedule of Benefits and to all other limitations and exclusions that apply. Only the amount of a charge that is Reasonable and Customary is considered a Covered Medical Expense or Covered Charge.

Covered Medical Expenses include the Reasonable and Customary Charges incurred for the following Medically Necessary services, supplies, and types of treatment:

8.1. HOSPITAL SERVICES AND SUPPLIES

A. Daily room and board, if semi-private or ward accommodations are used, and general duty nursing care excluding professional services of Physicians, private duty nurses or any individual nursing care, regardless of what it is called. If a private room is used, only the Hospital's most common charge for a semi-private room is a Covered Medical Expense.

B. Other Hospital services and supplies which are Medically Necessary and required for treatment excluding room and board, and professional services of Physicians and private duty nursing.

8.2. TRANSPORTATION SERVICES

1. Emergency local transportation by professional ambulance service other than Air Ambulance, limited to the first trip to and from the nearest Hospital qualified to perform the Medically Necessary services for any one Sickness and for all Injuries sustained in any one accident. The nearest Hospital may or may not be the Hospital where the individual wants to be treated; and

2. If the attending Physician certifies that an individual's disability requires specialized or unique treatment that is not available in a local Hospital, transportation to get to the treatment is covered, subject to the following limitations:

    1. The transportation must be by regularly scheduled commercial airline or railroad or by professional Air Ambulance;

    2. The transportation may only be from the town where the Injury or Sickness occurred to the nearest Hospital qualified to provide the special treatment, which may or may not be the Hospital where the individual wants to be treated;

    3. Only the first trip to and from the Hospital for any one Sickness and for all Injuries resulting from any one accident are covered; and

    4. The transportation is limited to the United States or Canada.

8.3. INPATIENT PHYSICIAN'S EXPENSE BENEFITS

This benefit covers expenses for services provided to you by your Physician when you are hospitalized on an Inpatient basis.

8.4. SURGICAL EXPENSE BENEFIT

Your surgical benefit covers surgical procedures and is based on a percentage payment not to exceed the amount on the Schedule of Benefits.

8.5. RECONSTRUCTIVE SURGERY

When incidental to or following surgery resulting from Injury, Sickness, or diseases of the involved part. This benefit includes:

A. Cosmetic surgery for the correction of defects incurred through traumatic Injuries sustained as a result of an accident when the treatment is performed within twelve (12) months of the accident (unless a Physician certifies that it is Medically Necessary to delay the cosmetic surgery for longer than twelve (12) months);

B. The correction of congenital defects which a Physician has certified has resulted in a function defect;

C. Corrective surgical procedures on organs of the body which perform or function improperly;

D. Voluntary vasectomies and other sterilization procedures for Employees, Retirees, and Dependent Spouses; and

E. Surgery to reconstruct a breast following a mastectomy procedure on the affected breast and: (i) any surgical procedure on the non-affected breast which is intended to provide a symmetrical appearance; (ii) any costs for prostheses related to the mastectomy procedure (i.e. implants, special bras); and (iii) the treatment of any physical complications associated with the mastectomy procedure.

8.6. PROPHYLACTIC MASTECTOMY The Plan will cover prophylactic mastectomy procedures if any of the following are present in the Eligible Individual:

1. A family history of breast cancer with (a) two (2) or more immediate relatives diagnosed with breast cancer, or (b) two (2) or more relatives with breast cancer in the same generation;

2. Cancer in one breast and an immediate relative with a history of breast cancer;

3. An immediate relative with bilateral pre-menopausal breast cancer;

4. A biopsy diagnosis of lobular carcinoma or atypical hyperplasia and either (i) an immediate relative with breast cancer, or (ii) breast cancer tissue density, scarring or calcification which precludes follow-up mammography's and physical examinations; or

5. A family history of hereditary cancer documented by family pedigree defined as Cowden's Disease, SBLA Syndrome or Ovarian/Breast Cancer Syndrome.

If the Eligible Individual is adopted and has no knowledge of family history, the Plan's medical advisor must review the file and approve the procedure.

For purposes of this prophylactic mastectomy benefit, "immediate relatives" will include an Eligible Individual's mother, sister or daughter. In addition, the term "relative" will further include an Eligible Individual's first cousin or grandmother.

8.7. BARIATRIC SURGERY

The Plan covers bariatric surgery subject to certain conditions, limitations, and exclusions (in addition to the conditions, limitations, and exclusions that apply to all Covered Medical Expenses). You must obtain prior authorization to qualify for coverage of bariatric surgery. For a copy of the additional conditions, limitations, and exclusions that apply to bariatric surgery, or for prior authorization, contact the Plan Administrator.

8.8. DIAGNOSTIC X-RAYS AND LABORATORY EXAMINATION BENEFIT

This benefit includes the services of radiologists and pathologists performed on an Outpatient basis.

8.9. MATERNITY BENEFIT EXPENSES

This benefit includes expenses for delivery in a Hospital and for services and supplies provided in connection with delivery in a birthing center or at home, including the services of a licensed midwife used instead of a Physician.

The Plan may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a caesarian section, or require that a provider obtain authorization from the Plan or any insurer for prescribing a length of stay not in excess of the above periods. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a caesarian section.

8.10. PREVENTIVE CARE AND IMMUNIZATIONS

8.10.1. Covered Preventive Care Services

The Plan will cover 100% of the Reasonable and Customary Charge for the following preventive care services for an Eligible Individual without application of the deductible.

A. Routine Physical Examinations. Routine physical examinations are covered for Employees, Retirees and Dependent Spouses; one examination per Calendar Year.

B. Colonoscopy. Colonoscopy coverage is applicable if Medically Necessary.

C. Services for Women. Mammography and Pap smear coverage is applicable if Medically Necessary.

D. Services for Men. Prostate Specific Antigen (PSA) Test coverage is only applicable to male Eligible Individuals forty (40) years of age and older and one procedure is covered per Calendar Year, unless there is a Medical Necessity requiring an additional PSA Test.

E. Services for Newborns. In addition to other benefits available to Dependent children, a newborn Dependent child will be entitled to: (i) routine nursery care and routine well baby care while Hospital confined due to birth; and (ii) coverage for Covered Expenses for Child Health Supervision Services. "Child Health Supervision Services" means Physician-delivered or Physician-supervised services including routine well baby care, pediatric

preventive services, developmental assessment, laboratory tests, and immunizations (as described below).

8.10.2. Preventive Care Services Described in the Affordable Care Act

The services listed below are those that the Affordable Care Act (ACA) specifies as preventive health care services. The Plan is voluntarily covering these services even though the Plan is not legally required to do so because it is a "grandfathered plan" as defined by the ACA. The Plan's Board of Trustees may decide not to cover items on the ACA list as long as the Plan continues to be a grandfathered plan. The ACA list of preventive health care services is subject to change from time to time. You may review the ACA list to determine what is covered at any time by going to the ACA website at https://www.healthcare.gov/what-are-my-preventive-care-benefits. You may also ask the Plan Administrator if you are not sure about coverage for these services.

The Plan will cover 100% of the Reasonable and Customary Charge for the following preventive care services for an Eligible Individual without application of the deductible.

8.10.3. Preventive Care Services for Adults

A. Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked;

B. Aspirin use to prevent cardiovascular disease for men and women of certain ages;

C. Blood Pressure screening for all adults;

D. Cholesterol screening for adults of certain ages or at higher risk;

E. Colorectal Cancer screening for adults over 50;

F. Depression screening for adults;

G. Diabetes (Type 2) screening for adults with high blood pressure;

H. Diet counseling for adults at higher risk for chronic disease;

I. HIV screening for everyone ages 15 to 65, and other ages at increased risk;

J. Immunization vaccines for adults--doses, recommended ages, and recommended populations vary: Hepatitis A, Hepatitis B, Herpes Zoster, Human Papillomavirus, Influenza (Flu Shot), Measles-Mumps-Rubella, Meningococcal, Pneumococcal, Tetanus-Diphtheria-Pertussis, Varicella;

K. Obesity screening and counseling for all adults;

L. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk;

M. Syphilis screening for all adults at higher risk; and

N. Tobacco Use screening for all adults and cessation interventions for tobacco users.

8.10.4. Preventive Care Services for Women

A. Anemia screening on a routine basis for pregnant women;

B. Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer;

C. Breast Cancer Mammography screenings every 1 to 2 years for women over 40;

D. Breast Cancer Chemoprevention counseling for women at higher risk;

E. Breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women;

F. Cervical Cancer screening for women at higher risk;

G. Chlamydia Infection screening for younger women and other women at higher risk;

H. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). The following contraceptive drugs and devices are covered if obtained through a Preferred Provider Pharmacy:

Product Category	Description
Oral Extended	Jolessa, Tab; Introvale, Tab; Quasense, Tab; Levonor/Ethi, Tab; Estradio
Oral Progestin	Norethindron, Tab 0.35mg; Errin, Tab 0.35mg; Camila, Tab 0.35mg; Lyza, Tab 0.35mg; Nora-Be, Tab 0.35mg; Jolivette, Tab 0.35mg; Camila, Tab 0.35mg; Errin, Tab 0.35mg; Jencycla, Tab 0.35mg; Heather, Tab 0.35mg
Oral Combo	Tri-Sprintec, Tab; Tri-Previfem, Tab; Tri-Estaryll, Tab; Tri-Linyah, Tab; Trinessa, Tab; Tri-Sprintec, Tab; Tri-Previfem, Tab; Norgest/Ethi, Tab Estradio;
Ella	Ella, Tab 30mg
Plan B	Levonorgestr, Tab 0.75MG; My Way, Tab 1.5mg; Next Choice, Tab 1.5mg; Levonorgestr, Tab 1.5mg
Transdermal Patch	Xulane Dis; Ortho Evra; Dis Week
Vaginal Ring	Nuvaring Mis
Cervical Caps	Prentif Mis; Femcap Mis
Diaphragms	All Flex, Coil Spring Kit, Flat Spring
Female Condom	FC Female Mis FC2 Female Mis

Product Category	Description
Sponge	Today Sponge Mis
Spermicide	VCF Vaginal; VCF Vaginal; Shur-Seal; C Gynol II; C Conceptrol; C Gynol II
Injection Progestin	Depo-Provera Inj; Depo SQ Prov Inj; Medroxypr AC Inj; Medroxypr AC Inj; Medroxypr Inj
Emergency OC	Next Choice, Tab; Plan B, Tab; My Way, Tab; Levorgestr, Tab; Take Action, Tab

I. Domestic and interpersonal violence screening and counseling for all women;

J. Folic Acid supplements for women who may become pregnant;

K. Gestational diabetes screening for women twenty-four to twenty-eight (24 to 28) weeks pregnant and those at high risk of developing gestational diabetes;

L. Gonorrhea screening for all women at higher risk;

M. Hepatitis B screening for pregnant women at their first prenatal visit;

N. HIV screening and counseling for at higher risk women;

O. Human Papillomavirus (HPV) DNA Test every 3 years for women with normal cytology results who are 30 or older;

P. Osteoporosis screening for women over age 60 depending on risk factors;

Q. Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk;

R. Sexually Transmitted Infections counseling for sexually active women;

S. Syphilis screening for all pregnant women or other women at increased risk;

T. Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users;

U. Urinary tract or other infection screening for pregnant women; and

V. Well-woman visits to get recommended services for women under 65.

8.10.5. Preventive Care Services for Dependent Children

A. Alcohol and Drug Use assessments for adolescents;

B. Autism screening for children at 18 and 24 months;

C. Behavioral assessments for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;

D. Blood Pressure screening for children at the following ages: 0 to 11 months, 1 to 4 years , 5 to 10 years, 11 to 14 years, 15 to 17 years;

E. Cervical Dysplasia screening for sexually active females;

F. Depression screening for adolescents;

G. Developmental screening for children under age 3;

H. Dyslipidemia screening for children at higher risk of lipid disorders at the following ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;

I. Fluoride Chemoprevention supplements for children without fluoride in their water source;

J. Gonorrhea preventive medication for the eyes of all newborns;

K. Hearing screening for children under age 18;

L. Height, Weight and Body Mass Index measurements for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;

M. Hematocrit or Hemoglobin screening for children;

N. Hemoglobinopathies or sickle cell screening for newborns;

O. HIV screening for adolescents at higher risk;

P. Hypothyroidism screening for newborns;

Q. Immunization and vaccines for children from birth to age 18 - doses, recommended ages, and recommended populations vary: Diphtheria-Tetanus-Pertussis, Haemophilus influenza type b, Hepatitis A, Hepatitis B, Human Papillomavirus, Inactivated Poliovirus, Influenza (Flu Shot), Measles-Mumps-Rubella, Meningococcal, Pneumococcal, Rotavirus, Varicella;

R. Iron supplements for children ages 6 to 12 months at risk for anemia;

S. Lead screening for children at risk of exposure;

T. Medical History for all children throughout development at the following ages: 0 to 11 months, 1 to 4 years , 5 to 10 years , 11 to 14 years , 15 to 17 years;

U. Obesity screening and counseling;

V. Oral Health risk assessment for young children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years;

W. Phenylketonuria (PKU) screening for this genetic disorder in newborns;

X. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk;

Y. Tuberculin testing for children at higher risk of tuberculosis at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years; and

Z. Vision screening for all children.

Services where medical treatment is provided or a diagnosis is given are not Preventive Care Services and charges related to such services are subject to the Plan Deductible, Copayment, and Coinsurance provisions.

8.11. NO SURPRISES ACT CLAIMS

Effective May 1, 2022, the Plan will cover (A) claims for Emergency Services provided by an out-of-network provider and/or at a non-Participating Health Care Facility; (B) claims for certain non-Emergency Services furnished to you by an out-of-network provider at a Participating Health Care Facility; and (C) claims for out-of-network Air Ambulance Services as though these items and services were provided by in-network providers. Note that claims of these types are still subject to the Plan's rules, regulations, limitations, and exclusions, including standard cost sharing requirements and coordination of benefits rules. The exact costs payable by you and the Plan for such claims will be determined in accordance with the rules and regulations established and in effect at the time the services are provided pursuant to the Consolidated Appropriations Act, 2021.

A. **Emergency Services Provided by an Out-of-Network Provider and/or at a Non-Participating Health Care Facility.**

Emergency Services provided by an out-of-network provider and/or at a non-Participating Health Care Facility will be covered as if provided by an in-network provider at a Participating Health Care Facility. This may include costs for additional items and services after the patient stabilizes, such as post-stabilization outpatient observation or inpatient or outpatient stays with respect to the visit for which the Emergency Services were initially furnished. Post-stabilization items and services will not be treated as in-network Emergency Services, however, if both of the following are true:

1. The attending Emergency Physician or treating provider determines that the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available in-network provider or Participating Health Care Facility located within a reasonable travel distance, taking into account the patient's medical condition; and

2. Except in cases where unforeseen, urgent medical needs arise, the out-of-network provider or non-Participating Health Care Facility furnishing the post-stabilization items and services satisfies the notice and consent criteria described below for non-Emergency Services provided by an out-of-network provider at a Participating Health Care Facility but subject to the following additional conditions:

   i. If the Hospital or Independent Freestanding Emergency Department is a Participating Health Care Facility but the provider is an out-of-network provider, the written notice must contain a list of any in-network providers at the Participating Health Care Facility who are able to furnish the items

and services involved and must notify the patient that he or she may be referred, at his or her option, to such an in-network provider; or

ii. If the Hospital or Independent Freestanding Emergency Department is not a Participating Health Care Facility, the written notice must include a good-faith estimate of the charges for items or services furnished by the facility or providers for the visit (and any items or services reasonably expected to be furnished by the facility or out-of-network providers in conjunction with those items or services).

B. **Non-Emergency Services Provided by an Out-of-Network Provider at a Participating Health Care Facility.**

1. When an Eligible Individual Covered Under the Plan receives non-Emergency Services covered by the Plan at a Participating Health Care Facility, the Plan will treat the following as Covered Medical Expenses provided by in-network providers (provided that all other criteria for coverage are met, e.g., the services are Medically Necessary):

i. Ancillary services, which are:

a. Items and services related to Emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a Physician or non-Physician practitioner;

b. Items and services provided by assistant surgeons, hospitalists, and intensivists;

c. Diagnostic services, including radiology and laboratory services; and

d. Items and services provided by an out-of-network provider if there is no in-network provider who can furnish such item or service at such facility.

ii. Items and services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished.

2. Ancillary services and items and services furnished as a result of unforeseen, urgent medical needs are treated as in-network items and services regardless of whether the out-of-network provider satisfied the notice and consent criteria described below.

3. Except as described above, Non-Emergency Services provided by an out-of-network provider at a Participating Health Care Facility will not be treated as Covered Medical Expenses if the provider or the Participating Health Care Facility (on behalf of the provider) satisfies notice and consent criteria by:

i. Providing the patient with a written notice within the time frame noted below, in paper form or, as practicable, electronic form (as selected by the patient),

provided separately from other documents, and containing the following information:

a. A statement that the provider is an out-of-network provider;

b. A good-faith estimate of the charges for the items and services involved or reasonably expected to be provided;

c. Notice that the estimate of charges or the patient's consent to be treated by the out-of-network provider is not a contract for the estimated charges or a contract to be treated by that provider or at that facility;

d. A statement that prior authorization or other care management limitations may be required before receiving further items or services at the facility; and

e. A clear statement that consent to receive items or services from the out-of-network provider is optional, that the patient may instead seek care from an available in-network provider, and that in such cases, cost sharing would be limited to in-network cost sharing amounts;

ii. Providing the written notice:

a. Not later than 72 hours before the date on which the patient is furnished the items or services, when the appointment is scheduled at least 72 hours in advance; or

b. Not later than three hours before the appointment, when the appointment is not scheduled at least 72 hours in advance;

iii. Obtaining from the patient (or authorized representative) a signed consent that is current (i.e., has not been revoked), that was obtained voluntarily (i.e., the patient must be able to consent freely, without undue influence, fraud, or duress), and that is in a form specified by the Department of Health and Human Services. The consent must:

a. Acknowledge in clear and understandable language that the patient (or authorized representative) has been provided the written notice described above in the form (mail or email) he or she selected and informed that the payment of out-of-network charges might not count toward a particular deductible, out-of-pocket maximum, or other cost sharing limitation;

b. State that by signing the consent, the patient agrees to be treated by the out-of-network provider and understands that he or she may

be balance-billed and subject to cost sharing requirements that apply to services furnished by the out-of-network provider; and

c. Document the time and date of receipt of the written notice described above and the time and date of the signed consent;

iv. Providing the patient with a copy of the signed written notice and consent in person, by mail, or by email; and

v. Making the notice and consent available upon request in any of the 15 most common languages in the state or geographic region and, for other languages, if the patient does not understand the notice and consent, obtaining the services of a qualified interpreter to assist the patient with understanding the notice and consent.

C. **Out-of-Network Air Ambulance Services.**

1. Air Ambulance Services provided by an out-of-network provider may be treated as in-network Covered Medical Expenses at in-network cost sharing amounts, without balance billing, and applied to your in-network deductible and in-network maximum out-of-pocket limitation in the same manner as if the Air Ambulance Services were provided by an in-network provider.

2. These rules only apply if the Air Ambulance Services meet all of the generally applicable criteria described above in Section 8.2 ("Transportation Benefits") related to Air Ambulance Service coverage.

8.12. OTHER COVERED EXPENSES

A. Dental services by a Physician for the treatment of a fractured jaw or accidental Injury to natural teeth. The Injury must be treated within six (6) months of the accident or during Total Disability, if Employee was Totally Disabled from the date of the accident, unless a delay in the commencement of treatment beyond the six (6) month period is Medically Necessary as supported by medical evidence from the treating Physician. Treatment includes replacement of teeth during that period.

B. Drugs and medicines which require the written prescription by a health care provider acting within the scope of his or her valid license and which cannot be purchased as an over-the-counter item; except, however, that insulin will be covered even if it is not prescribed as long as it is for the treatment of a diagnosed condition.

C. Consumable supplies necessary for the treatment of diabetes which has been diagnosed, such as insulin hypodermic needles and syringes.

D. The use of radium and radioactive isotopes.

E. Blood and blood plasma, not replaced by donated blood, and its administration.

F. Anesthesia.

G. X-ray and laboratory examinations.

H. Professional nursing services by registered graduate nurses or licensed practical nurses, other than a Close Relative.

I. Physiotherapy excluding physiotherapy treatment by a Close Relative.

J. Casts, splints, trusses, braces and crutches.

K. Oxygen and the rental of equipment for its administration.

L. Rental or purchase of durable medical equipment, such as a wheelchair, single Hospital-type bed, iron lung, or other similar item. Decisions related to payment of benefits under this provision, including, but not limited to, determinations of whether equipment should be rented or purchased, repaired or replaced, and the type of equipment most suited to a particular application will be made by the Trustees. Benefits under this paragraph will not exceed the purchase price.

M. Surgical dressings.

N. Surgical supplies, including appliances to repair or replace physical organs or parts of organs including items such as artificial limbs and eyes. Coverage is limited to one time per lifetime per artificial limb or eye. Also included are charges incurred for surgical supplies required to aid any impaired physical organ or part of an organ in its natural body function.

O. Wigs for hair loss related to chemotherapy or alopecia will be a Covered Expense under the Plan up to a maximum of $350 per Calendar Year and $1,400 in a lifetime.

P. Chiropractic Care and Services, subject to the Calendar Year maximum as specified on the Schedule of Benefits.

Q. Speech therapy for conditions related to neurological diseases and chronic ear infections. In addition, speech therapy will also be covered when it is Medically Necessary and is required due to an organic Illness or accidental Injury, provided it is rendered under a written treatment plan submitted to the Plan Administrator by the treating Physician and is approved by the Plan Administrator or Trustees in advance of the treatment. In any event, if special instruction and services related to speech therapy are available from the school district, speech therapy will only be covered once the special instruction and services have been exhausted and then only if the speech therapy is Medically Necessary.

R. Eye refractions for the diagnosis or treatment of Sickness or Injury.

S. The extraction of partially or completely un-erupted impacted teeth.

T. One course of diabetes management education every two (2) years, or more frequently with sufficient substantiation by the Eligible Individual's treating Physician of a significant change in the Eligible Individual's health status.

U. Effective March 13, 2020, and for the duration of the public health emergency concerning COVID-19, the Plan will cover 100% (at no member cost) in vitro diagnostic products based on an individualized clinical assessment or when ordered by an attending health care provider for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 that are approved, cleared, or authorized under the Federal Food, Drug, and

Cosmetic Act, and the administration of such in vitro diagnostic products. Also covered at 100% (no member cost share) are items and services furnished to Eligible Individuals during health care provider office visits (including both in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic product as described above, to the extent such items and services relate to the furnishing or administration of such product or to an Eligible Individual's evaluation for purposes of determining his or her need for the product.

V. Effective January 15, 2022, and for the duration of the public health emergency concerning COVID-19, the Plan will provide coverage for at-home over-the-counter ("OTC") COVID 19 test kits, subject to the following rules. The Plan will only cover COVID-19 test kits available "over-the-counter" that have been approved by the FDA for use at home or elsewhere without involvement of a health care provider or an individualized clinical assessment. The Plan will provide coverage for up to eight at-home COVID-19 test kits per Eligible Individual covered under the Plan every 30 days. The Plan will cover 100% of the cost of an at-home OTC COVID-19 test kit purchased at a Preferred Provider Pharmacy. Plan reimbursement for at-home OTC COVID-19 test kits that are not purchased at a Preferred Provider Pharmacy will be limited to the cost of the test or $12, whichever is less. The Eligible Individual is responsible for any amount in excess of $12 for an at-home OTC COVID-19 test kit purchased at a non-Preferred Provider Pharmacy or any other retailer or supplier.

8.13. HOSPICE CARE

Subject to the "Provisions Governing Hospice Care."

8.14. HOME NURSING CARE

Subject to the "Provisions Governing Home Nursing Care."

8.15. SKILLED NURSING FACILITY CARE

Subject to the "Provisions Governing Skilled Nursing Facility Care."

8.16. PREFERRED PROVIDER PHARMACY PRESCRIPTION DRUG BENEFITS

Subject to the "Provisions Governing Prescription Drug Benefits."

8.17. GENETIC TESTING

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act.

The Plan will cover diagnostic genetic testing and associated genetic counseling of an Eligible Individual if ALL of the following conditions are met:

A. Coverage is not otherwise excluded by the Plan.

B. Either:

1. The test is intended to detect breast, colon, or ovarian cancer in an Eligible Individual who has at least two (2) first degree relatives with a history of these cancers; or

2. The test is intended to detect pre-menopausal breast or ovarian cancer or colon cancer prior to age fifty (50) in an Eligible Individual who has at least one first degree relative with a history of these cancers; or

3. The Eligible Individual exhibits symptoms of a suspected disease that could not be definitively diagnosed after conventional diagnostic studies have been performed and for which there is medical evidence that a diagnosis could be determined through a genetic test.

C. The test result will immediately affect clinical care or, if the result is positive, will lead to the implementation of preventive or therapeutic measures which may prevent or palliate future disease in the Eligible Individual or his or her future children.

D. The sensitivity of the test is sufficient either alone or in conjunction with other factors such as family history so that the test result will provide appropriate guidance to the clinician.

E. The test is approved by the treating Physician and a Genetic Counselor. For purposes of this paragraph, the term "Genetic Counselor" means a health professional with a specialized graduate degree and experience in the areas of medical genetics and counseling.

F. Genetic testing and genetic counseling for the purpose of determining prescription drug efficacy are not covered by the Plan.

8.18. REPLACEMENT OF ORGANS AND TISSUE BENEFIT

Covered Medical Expenses include services, supplies, drugs, and related aftercare for approved human organ and tissue transplant, bone marrow transplant, and stem cell support procedures as provided below.

8.18.1. Approved Procedures Not Subject to Special Requirements

Charges incurred for kidney (excluding kidneys from live donors) and corneal transplants are approved for coverage if they (i) are Medically Necessary (which requires, among other things, that the transplants are not Experimental or Investigative) and (ii) are payable under all other provisions of this Plan Document. Kidney transplant (other than kidneys from a live donor) and cornea transplant procedures are not subject to the Special Requirements for Transplant Procedures discussed in Section 8.18.3 below.

8.18.2. Approved Procedures Subject to Special Requirements

The following transplant procedures are approved for coverage if they: (i) are Medically Necessary (which requires, among other things, that the procedures are not Experimental or Investigative); (ii) are payable under all other provisions of this Plan Document; and (iii) meet the Special Requirements for Transplant Procedures in Section 8.18.3. below:

A. Heart transplants;

B. Kidney transplants from a live donor

C. Heart-lung transplants;

D. Liver transplants;

E. Skin transplants;

F. Lung transplants (single or double);

G. Pancreas transplant for:

1. A diabetic with end-stage renal disease who has received a kidney transplant or will receive a kidney transplant during the same operative session; or

2. A medically uncontrollable, labile diabetic with one or more secondary complications, but whose kidneys are not seriously impaired.

H. Small-bowel and small-bowel/liver transplants; and

I. Bone marrow transplant and stem cell support procedures as follows:

1. Allogeneic and syngeneic bone marrow transplants and peripheral stem cell support; and

2. Autologous bone marrow transplants and peripheral stem cell support.

8.18.3. Special Requirements for Transplant Procedures

A. Authorization for a transplant procedure must be obtained from the Plan before the procedure is scheduled.

B. Transplant procedures are subject to case management by the Plan or a case manager designated by the Plan. At the time a request for authorization is made, the Administrative Manager will identify the Plan's case manager assigned to the transplant procedure.

C. Covered Medical Expenses incurred for services and supplies related to organ and tissue acquisition, including tissue typing and surgical, storage and transportation costs, are limited to a maximum benefit of $20,000.

D. If the transplant recipient is covered by this Plan, but the donor is not, medical expenses of the donor will be eligible for payment by the Plan, but only to the extent they are not covered by any other plan of benefits. Weekly Disability Benefits are not payable to an organ or tissue donor who is not an Eligible Individual under this Plan.

E. If the transplant donor is covered under this Plan, but the recipient is not, benefits will be considered for payment under this Plan only to the extent they are not payable under any other plan of benefits (including Weekly Disability Benefits). Benefits for expenses incurred by the recipient are not payable (except as provided in Paragraph G below).

F. A request for authorization of a transplant procedure must be supported by the written opinion of a Physician who is board certified as a specialist in the field of surgery applicable to the transplant procedure, and the written opinion must:

1. Identify the proposed recipient's medical condition for which the transplant procedure is requested;

2. Certify that the proposed transplant procedure is Medically Necessary for the treatment of the proposed recipient's condition and is not Experimental or Investigative as applied to such condition; and

3. Certify that no alternative procedure, service, or course of treatment would be effective in the treatment of the proposed recipient's condition.

Additionally, a written second opinion of a Physician is required for all proposed transplant procedures.

8.18.4. Excluded Expenses

Expenses related to the following are not covered (i.e., are excluded from coverage):

A. Services or supplies that are not reimbursed or payable under the provisions of this Plan.

B. Services unrelated to the covered transplant procedure or unrelated to the diagnosis or treatment of a Sickness resulting directly from the transplant.

C. Physician, Hospital, and other covered health care provider services or supplies for which no charge is made or for which no charge would routinely be made in the absence of coverage under this Plan.

D. Implant of an artificial or mechanical heart or part thereof. This exclusion does not apply to the Medically Necessary use of:

1. Ventricular assist devices used as a bridge to heart transplantation or as a bridge to recovery in patients with certain potentially reversible conditions; or

2. Total artificial hearts when used as a bridge to heart transplantation. Implantation of these devices is subject to additional limitations about which the Plan Administrator can provide information.

E. Cardiac rehabilitation services when not provided to the heart transplant recipient immediately following discharge from the Hospital after transplant surgery.

F. Drugs or medicines that are Experimental or Investigative, are used in clinical trials or research, are not widely accepted and used by the medical community, or have not been approved for general sale and distribution by the U.S. Food & Drug Administration.

G. Air Ambulance transportation, except for air transportation of the organ to the location of the surgery when the location is within a 500-mile radius. In the event of an emergency, the 500-mile radius restriction will be waived; however, in no event will the waiver apply to organs obtained outside of the United States or Canada.

H. Programs that are needed for Eligible Individuals to meet selection criteria for a transplant procedure, unless the particular program is otherwise covered under this Plan.

I. Services and supplies related to the procurement of a human organ or tissue that is not donated.

J. Any medical and surgical complications resulting from excluded treatments.

8.19. SELF-AUDIT PROGRAM

The Plan sponsors a Self-Audit Program. This program credits you and your family with twenty-five percent (25%) of any Plan savings resulting from identification of an error in bills, up to a maximum of $1,000 per Calendar Year, which will be credited to Employee's Premium Credit Account. Please contact the Administrative Manager for more information.

The Self-Audit Program is available to all Eligible Individuals who identify medical billing errors which:

1. Have not already been detected by the Administrative Manager or reported by the provider; and

2. Involve charges which are allowable and covered by the Plan.

To receive the Self-Audit Credit, the Eligible Individuals must:

1. Notify the Administrative Manager of the error before it is detected by the Plan or the health care provider;

2. Contact the provider to verify the error and obtain a corrected bill; and

3. Have copies of the correct billing sent to the Administrative Manager for verification, claims adjustment and calculation of the Self-Audit credit.

8.20. DENTAL AND ORAL SURGICAL SERVICES RELATED TO MEDICAL ILLNESS, DISEASE, OR MEDICAL TREATMENT OF ILLNESS OR DISEASE

The Plan will pay expenses for dental or oral surgical services for the repair or replacement of teeth lost due to medical illness, disease, or necessary and appropriate medical treatment of illness or disease or removed during an oral surgical procedure that is treated as a Covered Medical Expense under another provision of the Plan but only to the extent the charges incurred do not exceed the cost of the least costly effective treatment.

For the purposes of the dental and oral surgical services covered by the terms of this Subsection, Covered Medical Expenses include the fees of a duly licensed dentist or oral surgeon and other necessary ancillary expenses. No other expenses for dental or oral surgical services are included as Covered Medical Expenses. Dental services covered under this provision will be subject to the medical Deductible, Coinsurance, and out of pocket maximum provisions of the Plan. In addition, the covered dental and oral surgical services expenses described in this Subsection will be subject to a combined lifetime maximum limited of $10,000.

8.21. HEARING HEALTH CARE SERVICES DISCOUNT PROGRAM

The Plan offers a hearing health care services discount program which provides discounts on hearing health care services and high quality hearing instruments through a network of credentialed hearing health care providers.

8.22. TELEMEDICINE SERVICES

The Plan will cover telemedicine services through Teladoc without requiring a per visit Copayment. Telemedicine services provide access to Physicians, psychologists, and psychiatrists from any device with a front-facing camera (e.g., smartphone, tablet, or computer). Telemedicine services

are intended to complement existing care, not replace it. For emergency and chronic conditions, you should still visit your primary care provider or a Hospital.

Effective March 19, 2020 through the last day of the month in which the public health emergency related to COVID-19 ends, as determined by the Secretary of Health and Human Services, Secretary of Labor, and Secretary of the Treasury, the Plan will provide coverage for telemedicine services for $0 copayment by all UnitedHealthcare network providers that provide virtual care (telehealth) consultations. Effective the day after the last day of the month in which the public health emergency related COVID-19 ends, UnitedHealthcare network provider virtual care (telehealth) services will be covered subject to the Plan's standard deductible and coinsurance cost sharing for Preferred Provider Network services, and non-network virtual care (telehealth) services will be covered subject to the Plan's standard deductible and coinsurance cost sharing for non-network services.

Telemedicine services can treat most common non-emergency medical and mental health issues through live, face-to-face visits and may be used to treat both adults and children. Common medical issues treated include: cold and flu; allergies; skin and eye issues; sore throat; pediatric issues; prescription refills; sports injuries; and UTI and yeast infections. Common mental health issues treated include: stress; anxiety; relationship issues; depression; and addictions. Teladoc Physicians are able to prescribe a wide range of drugs; however, Teladoc Physicians do not prescribe narcotics or pain medications that have been designated as controlled substances.

Your Teladoc service appointment will be scheduled with a Physician or psychologist who is part of the Teladoc network and who is appropriately licensed and credentialed for the state you are in at the time of your visit. At your request, the telemedicine service provider will send a copy of a record of the visit to your primary care provider.

To use telemedicine services, you can download the Teladoc telemedicine service app (available through the Apple App Store the Google Play store). You can register in advance or at the time you would like to see a provider.

For more information about telemedicine services, contact the Administrative Manager, or visit https://www.teladoc.com/.

SECTION 9 PROVISIONS GOVERNING HOSPICE CARE

The Provisions Governing Hospice Care are part of the Plan's Major Medical Expense Benefit.

The Plan provides a Hospice Care Program for Eligible Individuals with Terminal conditions as explained below. Although Hospice Care Program benefits are paid under the Major Medical Expense Benefit, a special set of Covered Expenses applies to Hospice care.

Each Eligible Individual is entitled to Hospice Care Program benefits shown on the Schedule of Benefits.

9.1. SPECIAL DEFINITIONS

A. Hospice. A public agency or private organization (or a part of either), primarily engaged in providing a coordinated set of services at home or in Outpatient or institutional settings to individuals suffering from a Terminal medical condition. The agency or organization must be eligible to participate in Medicare; must have an interdisciplinary group of personnel that includes the services of at least one Physician and one RN; must maintain clerical records on all patients; must meet the standards of the National Hospice Organization; and must provide, either directly or under other arrangement, the "core services" listed as Hospice Care Program Covered Expenses.

B. Terminal, Terminally-Ill. The Eligible Individual's medical prognosis indicates a life expectancy of six (6) months or less.

C. Palliative Care. Care which is provided to a Terminally-Ill individual for the purpose of relieving or alleviating symptoms without curing.

D. Respite Care. Short-term Inpatient care provided to a Terminally-Ill individual only when necessary to relieve family members caring for him or her.

E. Period of Crisis. A period during which a Terminally-Ill individual requires continuous care which is primarily provided by a licensed nurse. This care must be necessary to achieve palliation or management of acute medical services.

9.2. ELIGIBILITY FOR THE HOSPICE CARE PROGRAM

A Physician must certify that an Eligible Individual's medical condition is Terminal. If the Eligible Individual is using a Hospice Physician as the primary Physician, only one certification is needed. If the Eligible Individual is using a personal Physician as well as a Hospice Physician, both Physicians must certify the condition as Terminal. The certification must be made no later than forty-eight (48) hours after the Eligible Individual begins receiving Hospice care.

9.3. EXPENSES

The Hospice Care Program's special set of Covered Expenses provides benefits for expenses that are not covered under the regular Covered Medical Expenses provisions of the Medical Expense Benefit. For this reason, an Eligible Individual must elect to use the Hospice Care Program for most of the care of his or her Terminal condition instead of receiving benefits for that care under the regular Covered Medical Expenses provisions. Any and all Palliative Care and most direct care of the Terminal condition will be received under the Hospice Care Program.

Surgical operations or Hospital confinements due to medical complications of the Terminal condition are paid under the regular Covered Medical Expenses provisions of the Medical Expense Benefit.

If a Terminally-Ill Eligible Individual incurs expenses for treatment of an Injury or Sickness totally unrelated to his or her Terminal condition, benefits for those expenses are payable under the regular Covered Medical Expenses provisions and limitations of the Medical Expense Benefit.

Once an Eligible Individual's condition is certified as Terminal, he or she can elect to use the Hospice Care Program. An Eligible Individual who wishes to receive Hospice care from a specific Hospice must complete an election form before any Hospice care is provided, the election form must be submitted through the elected Hospice.

9.4. REVOCATION

An individual can revoke the election to receive benefits under the Hospice Care Program at any time. If the election is revoked, no further benefits will be provided under the Hospice Care Program. Benefits for any further care and treatment of the Terminal condition will be provided only under the regular Covered Medical Expenses provisions and limitations of the Medical Expense Benefit.

Once the election is revoked, the right to Hospice Care Benefits is **permanently waived** and the Eligible Individual cannot be covered at any time in the future under the Hospice Care Program.

9.5. HOSPICE PROGRAM COVERED EXPENSES

Only Covered Expenses incurred for Hospice care of the Eligible Individual's Terminal condition apply under this Program. Covered Expenses include the following:

A. Nursing care by an RN or LPN;

B. Medical social services, under the direction of a Physician, which include:

   1. Assessment of the family member's social, emotional, and medical needs and the home and family situation;

   2. Identification of the community resources which are available to the family member;

   3. Assisting the family member to obtain those resources needed to meet the family member's assessed needs;

C. Psychological and dietary counseling;

D. Physical and occupational therapy and speech language pathology;

E. Non-prescription drugs used for Palliative Care;

F. Medical supplies, bandages and equipment, and drugs and biologicals used for pain and symptom control as prescribed by a Physician; and

G. Skilled nursing facility short-term Inpatient care to provide Respite Care, Palliative Care or care.

9.6. EXCLUSIONS AND LIMITATIONS OF THE HOSPICE CARE PROGRAM

Charges for the following services and supplies are not covered under the Hospice Care Program:

A. Any services or supplies not provided as "core services" by the Hospice providing the Hospice care;

B. Bereavement counseling (counseling services provided to a Terminal individual's family after death);

C. Administrative services;

D. Homemaker or caretaker services, which are services not solely related to care of the covered Eligible Individual, including:

1. Sitter or companion services for either the family member who is ill or other members of the family;

2. Housecleaning; and

3. Maintenance of the house;

E. Transportation, except in emergency situations;

F. Long-term Inpatient care (These charges are considered for payment under the regular Covered Medical Expenses provisions of the Major Medical Expense Benefit);

G. Surgical operations or Hospital confinements due to medical complications of the Terminal condition (These charges are considered for payment under the regular Covered Medical Expenses provisions of the Major Medical Expense Benefit); or

H. Any services or supplies provided for treatment of any Injury or Sickness other than the Terminal condition. (These charges are considered for payment under the regular Covered Medical Expenses provisions of the Major Medical Expense Benefit).

SECTION 10 PROVISIONS GOVERNING HOME NURSING CARE

The Provisions Governing Home Nursing Care are part of the Plan's Major Medical Expense Benefit.

10.1. COVERED NURSING CARE

Charges incurred for private duty home nursing care provided to an Eligible Individual after a Hospital confinement are Covered Expenses under the Plan's Major Medical Benefit, provided the following requirements are met:

A. The home nursing care must be certified as follows:

1. A program of home nursing care must be established and approved in writing by the Eligible Individual's Physician within seven (7) days following discharge from the Inpatient hospitalization; and

2. The Physician must certify that the home nursing care is for the same or related condition for which the Eligible Individual was hospitalized and that proper and Medically Necessary treatment of the Eligible Individual's condition would require Hospital confinement in the absence of the services and supplies provided as part of the program of home nursing care.

B. The program of home nursing care must be provided by or through an organization which meets the following definition of a Home Health Agency:

A "Home Health Agency" is a public agency or private organization (or a subdivision of the agency or organization) which meets all of the following requirements:

1. It is primarily engaged in providing skilled nursing services and other therapeutic services in the homes of its patients;

2. It has policies, established by a group of professional personnel associated with the agency or organization, governing the services which it provides. The professional group must include at least one Physician and at least one registered graduate nurse;

3. It provides for full-time supervision of its services by a Physician or a registered graduate nurse;

4. It maintains a complete medical record on each of its patients;

5. It is licensed according to the applicable laws of the state in which the patient receiving the treatment lives and of the locality in which it is located or in which it provides services;

6. It has a full-time administrator; and

7. It is eligible to participate in Medicare.

10.2. COVERED SERVICES AND SUPPLIES

Covered Expenses include charges incurred for the following services and supplies provided by or through a Home Health Agency:

A. Part-time or intermittent care provided by home health aides under the supervision of a registered graduate nurse;

B. Part-time or intermittent nursing care by a registered graduate nurse or licensed practical nurse if the Eligible Individual's condition requires the professional services of a trained nurse; and

C. Medical supplies (other than drugs and biologicals) provided by the Home Health Agency.

10.3. EXCLUSION

No payment will be made for child care or housekeeping services.

SECTION 11 PROVISIONS GOVERNING SKILLED NURSING FACILITY CARE

The Provisions Governing Skilled Nursing Facility Care are part of the Plan's Major Medical Expense Benefit.

A. Subject to the limitations shown on the Schedule of Benefits and as explained below, Covered Expenses under the Major Medical Expense Benefit include charges for room and board and Medically Necessary services and supplies provided to an Eligible Individual during an approved confinement in a Skilled Nursing Facility as defined below.

B. Benefits are payable for confinements in Skilled Nursing Facilities after a Hospital Inpatient confinement. The care is designed to provide the proper nursing care for an Eligible Individual who is well enough to leave the Hospital but is not yet well enough to go home.

11.1. REQUIREMENTS FOR AN APPROVED SKILLED NURSING CONFINEMENT

A. A Physician must certify that the confinement and nursing care are Medically Necessary for the Eligible Individual's recuperation from an Injury or Sickness;

B. The confinement must be preceded by at least three (3) consecutive days of a Hospital confinement for which Plan benefits are payable;

C. The confinement must start within three (3) days after discharge from the Hospital confinement for which Plan benefits are payable;

D. The confinement must be for the same condition which required the previous Hospital confinement; and

E. The confinement must be provided in a facility which meets the following definition of a "Skilled Nursing Facility". A Skilled Nursing Facility is an institution, or a distinct part of an institution, which has proper accreditation and fully meets all of the following criteria:

1. It is licensed to provide, and is primarily engaged in providing, on an Inpatient basis, skilled nursing care, physical restoration services and related services for patients who are convalescing from Injury or Sickness and who require medical or nursing care to assist the patients to reach a degree of body functioning to permit self-care in essential daily living activities;

2. It provides for patient services under the full-time (24-hour-per-day) supervision of one or more Physicians or one or more registered graduate nurse;

3. It provides 24-hour-a-day nursing services by licensed nurses under the supervision of a registered graduate nurse and it has a registered graduate nurse on duty at least eight (8) hours a day;

4. Every patient is under the supervision of a Physician, and it has available at all times the services of a Physician who is a staff member of a general Hospital;

5. It maintains daily medical records on all patients, and it provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;

6. It has an effective utilization review plan;

7. It has a transfer agreement with one or more Hospitals;

8. It is eligible to participate under Medicare; and

9. It is not, other than incidentally, an institution which is a place for rest, for custodial care, for the aged, for drug addicts, for alcoholics, a hotel, a place for the care and treatment of mental diseases or tuberculosis, or a similar institution.

SECTION 12 PROVISIONS GOVERNING PRESCRIPTION DRUG BENEFITS

No Plan benefits will be payable under the Preferred Provider Pharmacy Prescription Drug Benefit for any charges incurred by an individual who is enrolled in Medicare Part D.

The Plan has an agreement with CVS Caremark to provide prescription drugs at discounted prices. Under this agreement, CVS Caremark will provide retail and mail order prescription drugs through its network of pharmacies. Pharmacies that are members of that network are referred to in this Section as Preferred Provider Pharmacies.

Information regarding this program will be sent to you when you first become Covered Under The Plan.

You may call the Administrative Manager regarding the operation of this program.

12.1. PAYMENT OF BENEFITS (RETAIL PROGRAM)

When an Eligible Individual incurs an expense for prescription drugs at a Preferred Provider Pharmacy, benefits will be payable for federal legend drugs, insulin, and insulin syringes requiring a written prescription executed by a Physician or Dentist and dispensed by a licensed pharmacist.

Each Eligible Individual will receive a personal identification card to be used for obtaining prescriptions at participating pharmacies. If you lose your card or need an additional card, you may request that from the Plan Administrator.

The procedure for an Eligible Individual to obtain Prescription Drug Benefits from a participating pharmacy is:

A. Present the identification card to the pharmacist with the prescription;

B. Verify and sign the claim voucher prepared by the pharmacist; and

C. Pay the pharmacist the Copayment as determined under the Schedule of Benefits.

Only a single Copayment, however, will be assessed for multiple prescriptions for diabetic supplies (including insulin) that are submitted and filled in one visit.

Under this procedure, the pharmacist submits your claim for you. There should be no additional paperwork for you to handle.

If an Eligible Individual uses his or her personal identification card to obtain a prescription which is not covered under the Plan, the Eligible Individual will be responsible for reimbursing the Plan for the full amount less any Copayments made at the time of purchase.

If for some reason an Eligible Individual has not received an identification card, or if the prescription is being obtained from a non-Preferred Provider Pharmacy, then he or she must pay the pharmacist for the entire cost of the prescription at the time of purchase and submit a claim for reimbursement, including a paid receipt and copy of your prescription to:

CVS Caremark
P.O. Box 659541
San Antonino, TX 78265-9541

The Eligible Individual will be reimbursed for the lesser of the cost of the prescription or the amount the Plan would have paid for the prescription had it been purchased through a Preferred Provider Pharmacy less the Copayment, subject to these Plan rules.

12.2. PAYMENT OF BENEFITS (MAIL ORDER PROGRAM)

Eligible Individuals may also obtain discounted maintenance prescription drugs through the Mail Order Program or the ninety (90) day Retail Pharmacy program. Maintenance drugs are those medications taken on a long-term basis (more than thirty (30) days) for illnesses such as ulcers, diabetes, arthritis, and hypertension. These drugs are available in 90-day dosages.

The Administrative Manager has more information about how this program works. If you are going to take maintenance drugs, you should consider using one of these programs. When you do, the cost to you and the Plan is less.

The information packet distributed by the Administrative Manager contains the order form for you to use to order prescription drugs through the mail. The Administrative Manager has more of these forms if you need them.

To order by mail, you must complete the prescription order form and send it with your prescription and payment. You may also submit an order by way of the website at caremark.com. For subsequent fills of the same prescription, you may call 1- 866-818-6911 and you will be billed for the Copayment amount. You should allow ten (10) to fourteen (14) days for processing and delivery of your prescription drugs by mail.

The Copayment for a ninety (90) day dosage of maintenance drugs is the same as for prescription drugs filled through a local pharmacy (Please see the Schedule of Benefits for details). The maximum dosage limits are larger, however, under the mail order program, so you will likely save money by using the Mail Order Program.

12.3. DISPENSING LIMITATIONS

An Eligible Individual purchasing through the Retail Program is entitled to the amount of prescription legend drugs or insulin usually prescribed by the attending Physician or Dentist, but not to exceed a thirty (30) day supply, unless they are participating in the 90-day Retail program. A ninety (90) day supply is available for maintenance drugs through the Mail Order Program or the 90-day Retail Program.

12.4. UTILIZATION MANAGEMENT PROGRAM

CVS Caremark has a Utilization Management Program (UMP) for all prescription drugs. The UMP uses (a) prior authorization to ensure clinically appropriate use of medications, (b) step therapy/preferred products to encourage use of clinically effective front-line (lower cost) drugs before second-line drugs, and (c) quantity limits to regulate how often and how much of a drug can be dispensed. Some prescription drugs also may be subject to targeted quantity limits.

12.5. SPECIALTY DRUG PROGRAM

The Plan has implemented a Specialty Drug Program. Under the Specialty Drug Program, all specialty drug prescriptions must be obtained through the CVS Caremark to be covered under the Plan. The Utilization Management Program discussed in Section 12.4 above also applies to specialty prescription drugs.

Eligible Individuals who are eligible may enroll in CVS Caremark specialty drug program, which may reduce the Eligible Individual's Copayment for certain specialty drugs obtained through the CVS specialty pharmacy (Please see the Schedule of Benefits for details).

12.6. EXCLUSIONS

Benefits are not payable under this Section for:

A. Drugs which are lawfully obtainable without a prescription, except insulin and insulin syringes;

B. Therapeutic devices or appliances, including support garments and other nonmedical substances regardless of their intended use;

C. Administration of prescription legend drugs or injectable insulin;

D. Drugs labeled "Caution - limited by federal law for investigational use" or Experimental drugs, even if the individual is charged for the Investigational or Experimental drug;

E. Any compound drug that contains any chemical that has not been approved by the Food & Drug Administration;

F. Patent medicines or drugs, or any other medicine not legally dispensed by a registered pharmacist according to the written prescription of a Physician;

G. Refilling of a prescription in excess of the number specified by a Physician or Dentist;

H. Medication dispensed during Hospital confinement including confinement in a rest home, sanitarium, extended care facility, skilled nursing home, convalescent Hospital, nursing home, or similar institution which operates on its premises a facility for dispensing pharmaceuticals;

I. Any prescription drug expense if you are enrolled in Medicare Part D;

J. Diaphragms, contraceptive jellies and ointments, foams or devices;

K. Vitamins, cosmetics and dietary aids, except where classified as "prescription legend drugs"; and

L. Any expenses whatsoever under the Prescription Drug Benefit where payment will exceed a benefit limit or maximum set forth in the Schedule of Benefits.

SECTION 13 MENTAL HEALTH AND CHEMICAL DEPENDENCY BENEFIT

13.1. YOUR EMPLOYEE ASSISTANCE PROGRAM PROVIDED THROUGH TEAM

From time-to-time, we all deal with personal problems, both large and small. Sometimes we need help to resolve our problems. Your Employee Assistance Program, provided through TEAM is a confidential assessment, counseling, and referral service for you and your Dependents to help resolve personal problems which may be affecting your life at work and at home. This program is also available to Retirees.

Skilled counselors are available twenty-four (24) hours a day, every day of the year, to talk with you in confidence about your problems. Your United Healthcare counselor can help you with:

A. Family and marriage problems;

B. Alcohol or controlled substance dependency;

C. Financial concerns;

D. Emotional problems;

E. Legal referrals;

F. Medical concerns; and

G. Work-related problems.

For example, your counselor can help you find a nursing home for your father, recommend a new Physician, counsel a chemically dependent individual in your family, locate a marriage counselor for long-term counseling, or find a financial counselor to help you plan your budget. Talking to a professional about your problems can often help you gain a fresh prospective.

13.1.1. How To Use Your Employee Assistance Program

If you need help with a problem, call the confidential hotline at **(651) 642-0182 or (800) 634-7710**. Some problems can be resolved with a counselor in just a few minutes over the phone. Alternatively, you may choose to schedule a meeting with a counselor at any of TEAM's offices.

At the first meeting which lasts about one hour, your counselor will discuss your problems with you and determine the type of assistance you need. More meetings with your same counselor can be made, or, if you and the counselor decide that long-term counseling or treatment is needed, your counselor will refer you to an appropriate agency. You are encouraged to verify whether the referred counselor or agency is in the Preferred Provider Network before you begin counseling or treatment with a referred counselor or agency. Your TEAM counselor will follow up to make sure that you were satisfied with the service received and that your problem is being resolved.

The assessment, short-term TEAM counseling, and referral services are paid for by the Plan. If you are referred for long-term counseling or treatment, you are responsible for the cost of those services. The Plan may cover some of the long-term counseling and treatment costs associated with the care of chemical dependency, alcoholism and mental and nervous disorders. Your counselor will consider your particular employee benefits situation when suggesting a referral.

13.1.2. Coinsurance

Please see the schedule of benefits of information about coinsurance.

13.2. MENTAL AND NERVOUS DISORDER BENEFIT

13.2.1. Inpatient Treatment

A. Covered Charges for Inpatient treatment of mental or nervous disorders are payable under this Plan's Major Medical Expense Benefit. Please see the Section entitled "Major Medical Expense Benefits" for more details.

B. Covered Charges will also include daily room and board and other Hospital services and supplies (in accordance with the Coinsurance, Copayment, Deductible, and other provisions of the Plan's Major Medical Expense Benefit) for the purpose of providing Inpatient treatment for anorexia nervosa or bulimia, provided the following requirements are met:

1. The charges must be incurred at a treatment facility which is a state licensed behavioral health facility or is accredited by the Joint Commission on Accreditation of Health Care Organizations;

2. The facility must have a full-time psychologist or psychiatrist on staff; and

3. The treatment must be provided by licensed counselors.

13.2.2. Outpatient Treatment

Outpatient treatment must be provided by a Hospital, a facility licensed by the appropriate state agency of the state in which the treatment is provided as a Community Mental Health Center, a mental health clinic, or by a Physician. As used here, a "Physician" includes a licensed psychologist, a licensed consulting psychologist, or a licensed psychiatrist.

Exclusions. The following types of treatment are excluded from coverage under this Section:

Treatment and Diagnosis primarily relating to the following diagnosis taken from ICD - 9 - CM (International Classification of Diseases, 9th Review Clinical Modification, Volumes 1, 2, & 3), as follows:

Reserved

13.3. ALCOHOLISM AND CHEMICAL DEPENDENCY

The benefits shown below are provided for the treatment of alcoholism, chemical dependency or drug abuse; benefits are paid as any other Sickness.

13.3.1. Inpatient Treatment

A. Inpatient care must be received in a Hospital or an approved treatment facility. An "approved treatment facility" is one which is accredited by the Joint Commission on Accreditation of Health Care Organizations or one which meets certain requirements established by the Trustees.

B. The treatment must be provided in:

1. A Hospital which meets the Plan's definition of Hospital; or

2. A residential treatment program licensed by the appropriate state agency of the state in which the treatment is provided pursuant to diagnosis or recommendation by a Physician; or

3. A non-residential treatment program approved or licensed by the appropriate state agency of the state in which the treatment is provided.

C. If you, your Dependent Spouse or Dependent child receives Inpatient treatment for alcoholism or chemical dependency, the following benefits are paid as specified on the Schedule of Benefits:

1. Detoxification Treatment - Medical care for detoxification will be covered only if followed by an approved long-term, after-care program; and

2. Rehabilitative Treatment - Consultation and group therapy for rehabilitative treatment.

13.3.2. Outpatient Rehabilitative Treatment

The Plan covers individual, group and family therapy in a non-residential licensed treatment facility. Services of licensed Physicians and psychologists providing treatment under the supervision of Physicians are covered services.

SECTION 14 PREMIUM CREDIT ACCOUNTS REIMBURSEMENT PROGRAM

Due to the Plan's Deductible, Coinsurance, and Copayment requirements, you are responsible for paying a portion of many Covered Medical Expenses you and your Dependents incur. Similarly, you may be required to pay the dental and vision expenses you and your Dependents incur because the Plan does not cover dental and vision expenses. Subject to the requirements and conditions in this Section, you may use the Premium Credit Accounts Reimbursement Program to reimburse these types of expenses.

14.1. EMPLOYEES ACTIVELY WORKING IN COVERED EMPLOYMENT OR ACTIVELY SEEKING WORK IN COVERED EMPLOYMENT

This Subsection 14.1 applies to Employees who are actively working in Covered Employment or actively seeking work in Covered Employment.

If your Premium Credit Account has more Premium Credits than the amount needed as established by the Trustees to pay for three (3) months of coverage under the Plan, you can use the excess Premium Credits to be reimbursed for any portion of any out-of-pocket expense that constitutes medical care expenses as defined in Section 213(d) of the Internal Revenue Code which you incurred during the Plan Year if you were Covered Under the Plan and co-premiums for coverage under your Spouse's Health Plan that you or your Dependents must pay during the Plan Year. To use Premium Credits to pay co-premiums on your Spouse's Health Plan, you must first submit documentation satisfactory to the Plan Administrator demonstrating that your Spouse's Health Plan is compliant with ACA provisions and that your Spouse used after-tax dollars to pay the co-premium. Please contact your Plan Administrator for additional information. No reimbursement may draw your Premium Credit Account below the amount needed to pay for three (3) months of coverage.

14.2. RETIREES AND COVERED INDIVIDUALS WHO ARE NOT ACTIVELY WORKING IN COVERED EMPLOYMENT AND NOT ACTIVELY SEEKING WORK IN COVERED EMPLOYMENT

This Subsection 14.2 applies to (1) Retirees and (2) Covered individuals who are not actively working in Covered Employment and not actively seeking work in Covered Employment, whether or not they have applied for retirement.

If you have a balance in your Premium Credit Account, you may use your Premium Credit Account to be reimbursed for any portion of any out-of-pocket expense that constitutes medical care expenses as defined in Section 213(d) of the Internal Revenue Code which you incurred during the Plan Year if you were Covered Under the Plan, and co-premiums for coverage under your Spouse's Health Plan that you or your Dependents must pay during the Plan Year, even if the reimbursement depletes your Premium Credit Account below the amount needed to pay for three (3) months of coverage. To use Premium Credits to pay co-premiums on your Spouse's Health Plan, you must first submit documentation satisfactory to the Plan Administrator demonstrating that your Spouse's Health Plan is compliant with ACA provisions and that your Spouse used after-tax dollars to pay the co-premium. Please contact your Plan Administrator for additional information.

14.3. INDIVIDUALS SEEKING TO REQUALIFY FOR PLAN COVERAGE

An Eligible Employee whose coverage has terminated under the Plan and who does not make Self-Contributions for three (3) consecutive months, or who is unable to qualify for coverage under Sections 2.2 or 2.3 above due to lack of covered employment, may use his or her Premium Credit

Account to pay for monthly premiums sufficient and necessary to requalify for coverage or maintain eligibility. Please contact the Administrative Manager for additional information.

14.4. UNREIMBURSED MEDICAL EXPENSES INCURRED BY SURVIVING SPOUSE

The surviving Spouse of a deceased Eligible Employee may use the balance of the Eligible Employee's Premium Credit Account to be reimbursed for any out-of-pocket expense that constitutes medical care expenses as defined in Section 213(d) of the Internal Revenue Code incurred while the Eligible Employee was Covered Under the Plan, and Self-Contributions needed to maintain eligibility under the Plan. The deceased Eligible Employee's Premium Credit Account can be drawn down to zero (0). Please contact the Administrative Manager for additional information.

14.5. SUBMITTING A CLAIM FOR REIMBURSEMENT

You must submit a claim for reimbursement under the Premium Credit Accounts Reimbursement Program no later than June 30th of the year following the Calendar Year in which you or your Dependents incur the reimbursable expense. You may submit claims for reimbursement when it's convenient for you, but the Administrative Manager will process reimbursements just once per calendar month. To be reimbursed, you must submit a completed reimbursement claim form along with satisfactory documentation of the expense. Contact the Administrative Manager to request reimbursement forms.

The Administrative Manager will deduct a processing fee from your Premium Credit Account each time you submit one or more claims for reimbursement. The processing fee may change. Contact the Administrative Manager for the current processing fee. All the claims you submit together will be subject to a single processing fee. As a result, you may save on processing fees if you to periodically gather and submit multiple claims at one time.

SECTION 15 RETIREE BENEFITS

15.1. OVERVIEW

When you Retire, you can continue your coverage for yourself and your Dependents in one of two (2) ways:

A. Continuation Coverage Under COBRA is available up to eighteen (18) months for you and thirty-six (36) months for your Dependents, provided you or your Dependents make the correct Self-Contributions on time. Refer to "Continuation Coverage Under COBRA" Section in this booklet for more information. If you elect this Continuation Coverage under COBRA, you cannot be covered under the Retiree Benefits when COBRA coverage ends; or

B. Retiree Benefits are available for you and your Dependents as long as you make the correct Self-Contributions on time.

15.2. NOT AN ACCRUED BENEFIT

Retiree benefits are not an "accrued benefit." Retiree benefits can be changed, reduced, or eliminated at any time based on the decisions made by the Trustees.

15.3. ELIGIBILITY FOR RETIREE BENEFITS

The eligibility rules for Retirees are found in the Section of this booklet entitled "Eligibility."

15.4. PAYMENT OF SELF-CONTRIBUTIONS FOR RETIREE BENEFITS

The rules below apply for payment of Self-Contributions:

A. You must make your first Self-Contribution on or before the date on which a Self-Contribution is due to maintain continuous coverage. There must be no lapse in coverage between active Employee coverage and Retiree Benefits coverage, unless you elect to temporarily opt out of Retiree Benefits coverage as provided below.

B. The amount of the monthly Self-Contribution is determined by the Trustees and may be changed at any time.

C. You must mail your Self-Contributions to the Administrative Manager. The Administrative Manager must receive each Self-Contribution payment no later than the 1st day of the benefit month for which you are paying. For example, to be covered for benefits during the March benefit month, your Self-Contribution must be received no later than March 1st.

D. If you fail to make a Self-Contribution on or before the date it is due, your eligibility for Retiree Benefits will terminate at the end of the benefit month for which you have already paid. You will not be allowed to make any future Self-Contributions to reinstate Retiree coverage.

E. No notices of due Self-Contributions will be sent either to you or, in the event of your death, to your surviving Spouse or Dependents.

F. You may pay your monthly Self-Contribution for Retiree Benefits by way of automatic debits from a bank account. Please contact the Fund Office if you are interested in this option.

15.5. MEDICARE SUPPLEMENTAL BENEFITS

Health care coverage for you and your Dependents is the same as explained earlier in this booklet. Your benefits are figured as follows:

A. The amount of benefit available from this Plan is determined by the Schedule of Benefits;

B. The amount that Medicare pays is subtracted from the amount of benefit payable by this Plan; and

C. If the amount Medicare pays is larger than the amount of benefit available, no payment is made by the Plan.

15.6. SURVIVING DEPENDENTS OF RETIREES

15.6.1. Retiree Benefits – Surviving Spouse and Dependents

If your death occurs while you are making Self-Contributions for Retiree Benefits for yourself and your Dependents, your surviving Spouse can continue to make Self-Contributions for Retiree Benefits for himself/herself and any Dependent children, subject to the following rules:

A. The Self-Contributions must be made according to the above paragraph entitled "Payment of Self-Contributions for Retiree Benefits" as though the Self-Contributions were being made by you; and

B. Your surviving Spouse may continue to make Self-Contributions until your Spouse remarries, dies, or coverage terminates earlier according to the termination rules, whichever is earlier.

15.6.2. Retiree Benefits – Dependents and No Surviving Spouse

If your death occurs while you and your Dependents are eligible for Retiree Benefits and there is no surviving Spouse, or if your Spouse dies while making Self-Contributions for continued Retiree Benefits, your Dependent children or a legal guardian can make Self-Contributions for continued Retiree Benefits on behalf of the surviving Dependent children.

A. The Self-Contributions must be made according to the above paragraph entitled "Payment of Self-Contribution for Retiree Benefits" as though the Self-Contributions were being made by you.

B. Benefits for a surviving Dependent child will terminate before the termination of the allowable maximum coverage period on the date the child fails to meet the Plan's definition of a Dependent, unless coverage terminates earlier according to the termination rules.

15.6.3. Continuation Coverage Under COBRA Benefits

If your death occurs while you are making COBRA Self-Contributions to continue coverage for yourself and your Dependents, your surviving Dependents may be entitled to make Self-Contributions for Continuation Coverage Under COBRA subject to the following rules:

A. Continuation Coverage Self-Contributions may only be made for up to a maximum of thirty-six (36) months, minus the number of months of Self-Contributions you had made after your termination of active Employee coverage and before your death;

B. If your surviving Spouse should die while making Continuation Coverage Self-Contributions, any Dependent children or their legal guardian can make Self-Contributions for up to thirty-six (36) months, minus the number of Self-Contributions made by you and by your Spouse prior to your respective deaths; and

C. If your surviving Dependents do not elect to make Continuation Coverage Self-Contributions, they will not be permitted to make Self-Contributions for coverage under the Plan at any future date.

15.7. TERMINATION OF BENEFIT COVERAGE FOR RETIREES AND THEIR DEPENDENTS

15.7.1. Termination of Retiree Benefit Coverage

You will cease to be eligible for Retiree Benefits provided under the Plan on the first to occur of the following dates:

A. The date the Trustees terminate or discontinue this Plan of Benefits;

B. The date the Trustees terminate or discontinue Plan benefits for Retirees;

C. The last day of the benefit month preceding the benefit month for which you fail to make a proper and on-time Self-Contribution;

D. The date of your death; or

E. The occurrence of any event delineated in Subsection A, entitled; Bargaining Employees, Non-Bargaining Employees and Retirees of the "TERMINATION OF BENEFITS" Section.

15.7.2. Termination of Dependent Benefit Coverage

A Dependent of yours will cease to be eligible for benefit coverage under the Plan on the earliest of the following dates:

A. The date the Trustees terminate this Plan of Benefits;

B. The date the Trustees terminate Plan benefits for Retirees;

C. The date the Trustees terminate Plan benefits for Dependents of Retirees;

D. The date on which your eligibility for Plan coverage terminates for any reason other than your death;

E. The date on which the Dependent ceases to meet this Plan's definition of a Dependent unless the Dependent is entitled to elect, and does elect, and timely remits Self-Contributions for Continuation Coverage Under COBRA;

F. In the event of your death while you are making Self-Contributions for Continuation Coverage, at 11:59 p.m. of the last day of the last benefit month for which you had made a Self-Contribution before your death unless Self-Contributions for Continuation Coverage are made by or on behalf of the Dependent;

G. If Continuation Coverage Self-Contributions are being made by or on behalf of the Dependent, at 11:59 p.m. of the last day of the maximum coverage period to which the Dependent is entitled and for which a correct and on-time Self-Contribution has been made or on the date of occurrence of any of the events stated in "Termination of Continuation Coverage" whichever occurs first; or

H. In the event of your death while you are making Self-Contributions for Retiree Benefits:

1. At 11:59 p.m. of the last day of the last benefit month for which you had made a Self-Contribution before your death unless Self-Contributions are made by or on behalf of the Dependent;

2. If your surviving Spouse is making Self-Contributions to continue Retiree Benefits for himself/herself and any Dependent children:

   a. If a correct and on-time Self-Contribution fails to be made by or on behalf of the Dependent, by 11:59 p.m. of the last day of the last benefit month for which a correct and on-time Self-Contribution was made by or on behalf of the Dependent;

   b. The date the child fails to meet the definition of a Dependent child;

   c. With respect to the surviving Spouse, the date on which he or she remarries or dies, whichever occurs first; or

   d. With respect to a Dependent child in the event of the surviving Spouse's death, at 11:59 p.m. of the last day of the benefit month in which the Spouse's death occurs unless Self-Contributions are made by or on behalf of the Dependent child.

3. If Retiree Benefits for a Dependent child are being continued by Self-Contributions by or on behalf of a Dependent child because there is no surviving Spouse or because of the surviving Spouse's death:

   a. If a correct and on-time Self-Contribution is not made by or on behalf of the child, at the end of the last day of the last benefit month for which a correct and on-time Self-Contribution was made by or on behalf of the Dependent child;

   b. The date the child fails to meet the definition of a Dependent child; or

c. At 11:59 p.m. of the last day of the last month of the allowable maximum coverage period to which the child was entitled and for which correct and timely Self-Contributions have been made according to the rules.

4. The occurrence of any event delineated in Subsection A, entitled; Bargaining Employees, Non-Bargaining Employees and Retirees of the "TERMINATION OF BENEFITS" Section.

15.8. OPTION TO TEMPORARILY OPT OUT OF RETIREE BENEFITS COVERAGE

If you are otherwise eligible to obtain Retiree Benefits coverage at the time you Retire, you may also elect to delay beginning your Retiree Benefits coverage until a later time. If you wish to delay the effective date of your Retiree Benefits coverage, you must meet the following additional requirements:

A. At the time of your retirement and your election to temporarily opt out of Retiree Benefits coverage, you must be covered under your Spouse's health coverage or under government-sponsored health coverage, such as health coverage provided by the Veterans Administration; and

B. You will be allowed to opt back in to Retiree Benefits coverage under this Plan only if you later lose that other coverage due to your Spouse's retirement, death, or other termination of employment; or due to your involuntary loss of government-sponsored health coverage. You will not be allowed to opt back into Retiree Benefits coverage if the other coverage is lost for any other reason, such as a voluntary choice to drop the other coverage.

If you would like to take advantage of this Plan option:

A. You must notify the Plan Administrator in writing within thirty (30) days of the date of your retirement of your election to temporarily opt out of Retiree Benefits coverage and, at that time, provide the Administrative Manager with sufficient documentation to establish that you are covered under your Spouse's health plan or under government-sponsored health coverage.

B. You must notify the Administrative Manager in writing of your election to opt back into coverage under this Plan within thirty (30) days of the date your Spouse loses health coverage (or becomes eligible for Medicare) or, as the case may be, of the date you lose government-sponsored health coverage (or become eligible for Medicare) for the reasons stated above.

C. Your Retiree Benefits coverage under this Plan will then begin on the first day of the month following the month in which the Administrative Manager receives your written election to opt back into coverage under this Plan.

D. There can be no break in health care coverage between your Spouse's terminating coverage (or your terminating government-sponsored health coverage, as the case may be) and the beginning of your Retiree Benefits coverage under this Plan. So, you may be required to elect and pay for COBRA or COBRA-style continuation from the terminating health care coverage prior to the time your Retiree Benefits coverage begins under this Plan.

E. If you qualify to opt back into coverage, all of the requirements concerning Retiree Benefits coverage will apply, such as Self-Contribution requirements.

SECTION 16 PLAN CONDITIONS, LIMITATIONS AND EXCLUSIONS

SUMMARY

This plan is designed to pay for only certain types of benefits. This Section contains a list of various conditions, limitations and exclusions which apply. The list is provided only as an example. There may be other conditions, and exclusions and limitations that apply. The plan administrator can provide you with more information about the payment of claims.

No payment will be made under this Plan for losses sustained or charges incurred:

A. Resulting from any accidental bodily Injury, Sickness or disease sustained while the individual was performing any act of employment or doing anything pertaining to any activity for remuneration or profit.

B. Resulting from any accidental bodily Injury, Sickness or disease for which benefits are or may be payable in whole or in part under any Workers' Compensation Act or any Occupational Diseases Act or any similar law. However, the Plan will consider advancing medical expenses payable in whole or in part under Workers' Compensation Law if the Plan receives from the Eligible Individual a fully signed subrogation acknowledgment form required by the Trustees and the Eligible Individual pursues to the satisfaction of the Trustees a Workers' Compensation claim or other claim under any Occupational Diseases Act or similar law with the appropriate state agency or agencies.

C. For treatment, care, services, supplies or procedures provided while an Eligible Individual is confined in a Hospital operated by the U.S. Government or its agency, provided, however, that if the charges are made by a Veterans Administration ("V.A.") Hospital which claims reimbursement for the "reasonable cost" of care furnished by the V.A. for a non-service related disability, to the extent required by law, the charges will be considered Covered Expenses to the extent that they would have been considered Covered Expenses had the V.A. not been involved.

D. By an Eligible Individual which the Eligible Individual is not legally required to pay.

E. Which would not have been made or payable if this Plan did not exist.

F. To the extent permitted by applicable law, for charges incurred in connection with any Sickness contracted or Injury sustained prior to the date Medical Benefits become effective.

G. For any services or treatment not specifically covered under this Plan or required to be covered by law.

H. For any service, supply, treatment or procedure which is not rendered for the treatment or correction of, or in connection with, a specific illness, Sickness or accidental bodily Injury unless specifically identified as Covered Medical Expense under the Plan.

I. Except as otherwise provided, for dental services and supplies rendered (whether or not rendered in a Hospital setting) for treatment of the teeth, the gums (other than for tumors) or other associated structures primarily in connection with the treatment or replacement of teeth, including treatment rendered in connection with mouth conditions due to

periodontal or periapical disease, or involving any of the teeth, their surrounding tissue or structure, the alveolar process, or the gingival tissue, unless the charges are for services rendered for the repair of accidental Injury to sound natural teeth (EXCEPT: This exclusion does not apply to the extraction of partially or completely un-erupted impacted teeth).

J. For Hospital charges incurred in connection with an Inpatient Hospital confinement for the purpose of dental treatment for which there exists no written certification by a Physician that the Inpatient Hospital confinement is Medically Necessary for the treatment.

K. For any care or treatment of an Eligible Individual in excess of the maximum benefit limitations for that type of care and treatment as specified on the Schedule of Benefits.

L. For any charge or portion of a charge that is determined to be in excess of the amount considered to be Reasonable and Customary.

M. For any chiropractic treatment in the balance of a Calendar Year in which an individual has already received payments for chiropractic treatment in excess of the maximum specified on the Schedule of Benefits in that Calendar Year.

N. For a physical examination in excess of amounts covered under the Plan's routine physical examination benefit unless the exam is to determine whether an individual has a specific illness, Sickness, or disease.

O. For charges incurred in connection with any Injury or Sickness for which the Eligible Individual is not under the regular care of a Physician.

P. For charges incurred for any services or treatments not prescribed by a Physician, e.g. vitamins, cough medicine, aspirin, Nicorette®, cosmetics, soap, toothpaste, nicotine patch, etc.

Q. For drugs or medicines prescribed by a Physician which are available as over-the-counter purchases (e.g., aspirin, cough medicine, vitamins, or nutritional supplements).

R. For drugs or medicines not legally dispensed by a registered pharmacist according to the written prescription of a Physician.

S. Under any part of this Plan for prescription drugs by an Eligible Individual who is enrolled in Medicare Part D.

T. For elastic bandages or stockings (EXCEPT: those that are determined to be Medically Necessary and are provided during the course of an Inpatient or Outpatient course of treatment).

U. For hearing aids and/or exams related to the fitting of hearing aids, except as otherwise covered under the Plan.

V. For the rental or purchase of any durable medical equipment or other equipment that is not used solely for therapeutic treatment of a single individual's Injury or Sickness.

W. For any of the following listed items, regardless of intended use, including but not limited to: air conditioners, air purifiers, whirlpools, swimming pools, humidifiers, dehumidifiers, allergy-free pillows, blankets or mattress covers, electric heating units, orthopedic mattresses, exercising equipment, vibratory equipment, elevators or stair lifts, blood

pressure instruments, stethoscopes, clinical thermometers, scales, wigs (EXCEPT: those required due to hair loss caused by chemotherapy or alopecia up to a maximum benefit amount of $350.00 per Calendar Year of $1,400 per lifetime), and, except as specifically provided under the Section of this booklet entitled "Covered Medical Expenses" in connection with a mastectomy procedure, devices or surgical implantations for simulating natural body contours.

X. For education, training or room and board while an Eligible Individual is confined in an institution which is primarily a school or institution of learning or training.

Y. For special education provided to an Eligible Individual, regardless of the type or purpose of the education, the recommendation of the attending Physician or the qualifications of the person providing the education. Exception: This exclusion does not apply to diabetes management education as specifically described in this Summary Plan Description.

Z. For any physical or occupational therapy that is not part of a treatment plan preauthorized by the Plan or for any type of therapy if either the prognosis or history of the individual receiving the treatment or therapy does not indicate to the Trustees a reasonable chance of improvement, unless provided under the Section of this booklet entitled the "Provisions Governing Hospice Care."

AA. For charges for or related to membership in a health or fitness club/facility except as otherwise covered under the Plan.

BB. For any type of speech therapy except as stated in "Covered Medical Expenses."

CC. For any type of custodial care, which is care designed primarily to assist an individual in meeting the activities of daily living, regardless of what the care is called.

DD. For any care or treatment of an Eligible Individual provided by an individual who is a Close Relative or who ordinarily lives in the Eligible Individual's home.

EE. While an individual is confined in an institution which is primarily a place of rest, a place for the aged, or a nursing home (unless the home meets the definition of a "skilled nursing facility" under the Section of this booklet entitled "Provisions Governing Skilled Nursing Facility Care").

FF. For any individual or private nursing care except as provided in accordance with the "Provisions Governing Home Nursing Care."

GG. For any hospice care, except as provided in accordance with the "Provisions Governing Hospice Care."

HH. For any confinement in a nursing facility, except as provided in accordance with the "Provisions Governing Skilled Nursing Facility Care."

II. For any treatments, care, services or supplies that are not Medically Necessary.

JJ. For any treatment, care, services, supplies, procedures or facilities that are Experimental or Investigative.

KK. For any care, treatment, or surgery that is elective and not Medically Necessary or otherwise specifically stated in the Plan as a Covered Expense, such as non-Emergency

plastic or cosmetic surgery on the body (including, but not limited to, the eyelids, nose, face, breasts or abdominal tissue).

Exception: This exclusion does not apply to:

1. Cosmetic surgery for the correction of defects incurred through traumatic injuries sustained as a result of an accident when the treatment is performed within twelve (12) months of the accident (unless a Physician certifies that it is medically necessary to delay the cosmetic surgery for longer than twelve (12) months);

2. The correction of congenital defects which has resulted in a function defect as determined by a Physician;

3. Corrective surgical procedures on organs of the body which perform or function improperly;

4. Voluntary vasectomies and other sterilization procedures for Employees, Retirees, and Dependent Spouses; and

5. Prophylactic Mastectomy procedures as defined under the Section of this booklet entitled "Covered Medical Expenses."

LL. For medical or surgical treatment of weight–related disorders (such as obesity and morbid obesity) including, but not limited to, surgical interventions, dietary programs, prescription drugs, and related Physician visits (EXCEPT: as specifically stated in the "Covered Medical Expenses" Section of this Summary Plan Description.

MM. For any treatments, care, services or supplies which are not recommended or approved by the attending Physician.

NN. For services or supplies received from a physician or hospital that do not meet this Plan's definition of a Physician or a Hospital.

OO. For any in-Hospital items such as telephones, televisions, cosmetics, newspapers, magazines, laundry, guest trays, or beds or cots for guests or other family members, or any other personal comfort items or items that are not Medically Necessary.

PP. For charges incurred in connection with acupuncture unless prescribed for pain management.

QQ. For massage therapy.

RR. For any type of service or supply provided in connection with smoking cessation, including, but not limited to, medications (prescription or non-prescription) and therapy or counseling of any type.

SS. For the completing of claim forms (or any forms required by the Plan Administrator for the processing of claims) by a Physician or other provider of medical services or supplies.

TT. For travel, whether or not recommended by a Physician, except as stated in "Covered Medical Expenses."

UU. As a result of treatment or consultation with a social worker or marriage counselor. Exception: This exclusion does not apply to services provided for an individual who has elected to receive benefits under the Hospice Care Program or to short-term marriage counseling, assessment, and referral services provided through the Employee Assistance Program (as described in the Section of this booklet entitled "Mental Health and Chemical Dependency Benefit").

VV. For routine eye examinations (except for routine eye examinations for children under age nineteen (19)), eye refractions (except as specifically described in the "Other Covered Expenses" under the Section of this booklet entitled "Covered Medical Expenses"), eyeglasses, contact lenses (except the first pair of contact lenses required following cataract surgery), hearing aids, or dental prosthetic appliances, including any charges made for the fitting of any of these appliances, unless the service or supply was rendered as a result of non-occupational accidental bodily Injury.

WW. For a radial keratotomy (a surgical procedure to correct nearsightedness).

XX. For charges for or related to genetic engineering and testing except as covered in the Genetic Testing provisions stated in the "Covered Medical Expenses" Section.

YY. For charges incurred by Dependent children for vasectomies or other sterilization procedures unless recommended by a Physician for therapeutic purposes of the patient.

ZZ. For the reversal of, or attempts to reverse, a previous elective sterilization.

AAA. For hormone therapy, artificial insemination, charges incurred in connection with or related to conception, pregnancy or delivery in connection with a surrogacy arrangement, or any other direct attempt to induce or facilitate fertility or conception.

BBB. For charges incurred in connection with any pregnancy for which benefits are payable under any prior plan of group insurance.

CCC. For charges incurred in connection with voluntary abortion (EXCEPT: This exclusion will not apply to an abortion performed on the Eligible Individual whose pregnancy is the result of assault or when the pregnancy will endanger the life of the mother).

DDD. For nursery charges beyond the joint confinement of the mother and child or after the end of the period that either the mother or newborn child is no longer medically required to remain in the Hospital. In determining a mother's maximum period of medically required confinement, the period of a normal maternity confinement is used. In the event of termination of nursery charges for a newborn child, benefits are payable for the newborn child only if all other eligibility rules of the Plan have been met for that child.

EEE. For charges or benefits that are provided for or paid for by a program of the federal, state or city government, including Medicare, TRICARE, Medicaid, and statutory disability benefits.

FFF. For services to treat a Sickness, illness or Injury determined by the Secretary of Veterans Affairs, to have been incurred in, or aggravated during, performance of service in the uniformed services.

GGG. For services or supplies furnished, paid for or otherwise provided due to an Eligible Individual's past or present service in the armed forces of any government.

HHH. For services or supplies to treat any Injury or Sickness incurred in, or aggravated during, a Covered Person's past or present participation in an Act of War. For purposes of this exclusion, "Act of War" includes any act or conduct during war, declared or undeclared, act of terrorism, insurrection, or war-like activity by any individual, government, military, sovereign group, terrorist or other organization.

III. For charges resulting from any intentionally self-inflicted Injury (EXCEPT: This exclusion does not apply to: (i) intentionally inflicted Injuries to the Dependent children of Eligible Employees; or (ii) self-inflicted Injuries resulting from the physical or mental health condition of the Eligible Individual).

JJJ. For charges for an Injury or Sickness resulting from engaging in an illegal act. For purposes of this Paragraph (JJJ), "illegal act" will mean any illegal occupation or any conduct that constitutes and may be charged as a gross misdemeanor or felony offense under the laws in the State of Minnesota, or equivalent laws of the state in which the occupation or conduct occurred, regardless of whether the Eligible Individual is actually charged with or convicted of the illegal act constituting the felony or gross misdemeanor (or equivalent charge). (EXCEPT: Subject to the other limitations and exclusions provided in this document, any loss, expense or charge related to an act of domestic violence committed against the Eligible Individual, or if the illegal act is related to a physical or mental health condition of the Eligible Individual).

KKK. For charges for any Injury, Sickness, or condition that results from an incident occurring on any property which is covered under a policy of homeowner's, premises liability, or commercial liability insurance. If no insurance or other form of compensation is available to the Eligible Individual, the Plan will consider the charges only if the Plan receives from the Eligible Individual a fully signed subrogation acknowledgment form required by the Trustees. Prior to the payment of any benefits, the Eligible Individual must establish to the satisfaction of the Trustees that he or she has made a diligent effort to find out if there is an applicable homeowner's or premises liability policy; and, if such a policy exists, the Eligible Individual has exhausted coverage under any medical payment provision of the policy.

LLL. For charges incurred as a result of any automobile, motorcycle, watercraft or other recreational vehicle or motorized vehicle (collectively "Vehicle") accident:

1. Where the Eligible Individual fails to obtain and/or maintain the statutory minimum level of no-fault medical insurance protection, provided that the Eligible Individual is required by the state statute to maintain the coverage (this paragraph will only apply to the amount of the no-fault insurance as required);

2. Where there is applicable no-fault coverage but the Eligible Individual has failed to apply for the coverage;

3. Where the no-fault carrier had determined the charges not to be "Reasonable or Customary" or are not "Medically Necessary";

4. Where the no-fault carrier denied charges and/or coverage prior to the exhaustion of all no-fault benefits available under the applicable policy and the Eligible Individual did not arbitrate the denial;

5. In states without a no-fault statute, where the Eligible Individual does not first exhaust medical payment coverage on the vehicle(s) involved in the accident; or

6. Where the Eligible Individual, whether or not a minor, has a right to recover or claim a right to recover or has already recovered from a Third-Party, in which event the provisions of exclusions (MMM) through (UUU) will apply.

MMM. In the event the no-fault carrier disputes coverage under a no-fault policy of insurance for the Eligible Individual, the Plan may require the Eligible Individual to arbitrate the denial of coverage before payment or continuing payment of benefits.

NNN. For charges for any injury or condition that is the result of the actions of a Third-Party to the extent an Eligible Individual is awarded future medical costs or general compensatory damages in a lawsuit or settles a claim which includes payments covering future medical expenses or "pain and suffering" damages.

OOO. For charges for any Injury or Sickness that is the result of the actions of a Third-Party if the Eligible Individual settles, compromises or successfully adjudicates his or her claim against the Third-Party or the Third-Party's insurance carrier without notifying the Plan Administrator. This provision applies regardless of whether the Plan has paid benefits if there is a reasonable likelihood the Eligible Individual will make a claim to the Plan.

PPP. Any charges resulting from an accidental bodily Injury or Sickness for which the Eligible Individual, whether or not a minor, has not submitted all charges incurred as a result of the bodily Injury or Sickness prior to resolution of the Third-Party claim.

QQQ. Any loss, expense, or charge for which a Third-Party may be liable for which the individual on whose behalf the claim was filed did not submit the required subrogation acknowledgment form required by the Trustees to the Plan.

RRR. Any loss, expense or charge (1) for which a Third-Party may be liable and (2) for which either (a) a recovery subject to the Plan's subrogation and reimbursement rights has been received (whether before or after the submission of or payment of claims by the Plan), or (b) the Plan deems it likely that recovery will be received. At the discretion of the Trustees, losses, expenses and charges excluded by this paragraph may be paid subject to the Plan's rights of subrogation and reimbursement; provided, the Plan receives a fully signed subrogation acknowledgment form approved by the Trustees and the Eligible Individual pursues to the satisfaction of the Trustees a claim against any Third-Party that may be liable for the loss, expense or charge.

SSS. Any loss, expense or charge incurred as the result of any injury, occurrence, condition or circumstance for which an Eligible Individual:

1. Has the right to recover payment from a Third-Party. At the discretion of the Trustees, losses, expenses and charges excluded by this paragraph may be paid subject to the Plan's rights of subrogation and reimbursement; and provided, that the Plan receives from the Eligible Individual a fully signed subrogation acknowledgment form approved by the Trustees and the Eligible Individual;

2. Pursues to the satisfaction of the Trustees a claim against any Third-Party that may be liable for the loss, expense or charge;

3. Has recovered from a Third-Party. This means that after the Eligible Individual receives a recovery the Plan may deny any loss, expense or charge submitted to or remaining unpaid by the Plan that, in the sole discretion of the Trustees, is related to the injury, occurrence, condition, or circumstance giving rise to the recovery; or

4. Has not submitted a claim for the loss, expense, or charge prior to resolution of the Third-Party claim, regardless of whether the claim relates to a date of service prior to the resolution of the claim.

TTT. Any loss, expense or charge of an Eligible Individual if the Eligible Individual has failed to honor the Plan's rights of subrogation and reimbursement, prejudiced or adversely affected the Plan's rights of subrogation and reimbursement, or otherwise failed to cooperate with the Plan, as set forth in this Plan document. The Plan also may deny claims pursuant to this paragraph that otherwise would be covered under this Plan of an individual eligible for benefits under the Plan based upon that individual's relationship to the Eligible Individual to offset benefits the Plan previously paid subject to the Plan's first priority rights of subrogation and reimbursement.

UUU. Any losses incurred by an Eligible Individual at a time that the Eligible Individual or any member or former member of the Eligible Individual's family, owes payment or reimbursement to the Plan, because of benefit overpayments or because of payments made in reliance upon incorrect, misleading or fraudulent statements or representations in connection with coverage under this Plan.

The list above is NOT an all-inclusive listing of excluded services and supplies. It is only representative of the types of services and supplies for which no Plan payment is made and of the types of situation in which loss may be sustained or in which expenses may be incurred for which no payment is made under this Plan. The Eligible Individual may be reimbursed under the Premium Credit Accounts Program for any excluded services and supplies that constitute a Code Section 213(d) expense, subject to the terms of the Premium Credit Accounts Program.

SECTION 17 PAYMENT OF BENEFITS

SUMMARY

The next few Sections of the booklet describe many general rules that apply to all types of benefits you may receive under the Plan. Some of the more important rules are listed below.

A. The Trustees of the Plan have the sole authority to interpret this document, and any other documents concerning the Plan.

B. Similarly, the Trustees may amend or modify the Plan at any time. No benefits or conditions of the Plan are promised or guaranteed to continue.

C. Your claims for benefits must be filed within certain time limits described in these Sections.

D. If someone else is legally responsible to pay for an Injury or Sickness they have caused you, the Plan may recover the amount of benefits it has paid as a result of that Injury or Sickness. The Plan's right to so recover is known as the right of "subrogation" and "right of reimbursement."

Quite often an Eligible Individual may be covered under more than one (1) health care plan. For instance, a husband may be covered under this Plan as an Employee, and covered under his wife's plan as a dependent. The Trustees of this Plan have adopted rules that determine which plan(s) must pay for benefits and in what order. Those "Coordination of Benefits Rules" are described in this Section.

This Section of the booklet also describes the claims appeal procedures that you and the Trustees must follow if your claim for benefits is partially or totally denied. You may appeal a denial to the Board of Trustees.

17.1. RULES GOVERNING PAYMENT OF BENEFITS

The following rules affect the payment of benefits from this Plan:

A. Benefits payable for any loss will be paid upon timely and complete receipt by the Trustees, or their duly appointed representative, of written proof of loss covering the occurrence, character, and extent of the event for which claim is made.

B. All benefits under the Plan are payable on a reimbursement basis, unless otherwise stated. If you or your Eligible Dependent is injured in an accident or becomes sick, the Plan will reimburse you for the actual amount of the charges incurred for care and treatment up to the amount shown in the "Schedule of Benefits." The Administrative Manager may review and compare similar charges made by other providers for similar services or supplies in the area to individuals of similar age, sex, circumstances and medical condition.

C. "Covered Expenses" and "Covered Medical Expenses" are used to indicate certain types of charges that are acceptable to be considered for payment. This does not mean that all incurred Covered Expenses will be paid. Payment will be made based on the provisions of each benefit, the limitations shown in the "Schedule of Benefits" and the "Plan Conditions, Limitations and Exclusions" Sections of this booklet.

D. Payments are made for treatment of Injuries only if they are: (i) accidental Injuries; or (ii) self-inflicted Injuries resulting from the physical or mental health condition of the Eligible Individual.

E. Payments are made for treatment of Injuries and Sicknesses only if they are nonoccupational (not related to work).

F. Any medical service or supply which an Eligible Individual receives must be Medically Necessary and must be received upon the recommendation of, or with the approval of, a Physician who is acting within the scope of his or her license.

G. Charges are considered for payment only if they are incurred while the individual is Covered Under the Plan.

H. A charge for any service, treatment or supply will be considered to have been incurred on the date the service or treatment was rendered or on the date the supply was provided.

I. Benefits will be payable only for expenses which are actually incurred.

J. The self-funded (self-insured) benefits payable under this Plan are limited to the assets available for those purposes regardless of accumulated eligibility.

K. Expenses incurred by female Eligible Individuals for a maternity or pregnancy-related condition are treated the same as expenses incurred for a Sickness.

L. When a year is used without expressly designating the year as a Calendar Year or Plan Year, it means a Calendar Year, which begins on January 1 and ends on December 31 of that year.

M. Your life benefit will be paid to your Beneficiary.

N. If the Trustees decide that an individual is not mentally, physically or otherwise capable of handling his or her business affairs, the Plan may pay benefits to a guardian or to the individual who has assumed care and principal support if there is no guardian. If the Employee dies before all due amounts have been paid, the Trustees may make payment to the executor or administrator of the estate, to the surviving Spouse, parent, child or children or to any individual the Trustees believe is entitled to the benefits.

O. Benefits are payable only when the required forms and information have been received by the Plan. Any payments made by the Plan according to the above rules will fully discharge the Plan's liability to the extent of its payments.

P. There are conditions, limitations and exclusions which apply to certain types of charges. Refer to the "Plan Condition, Limitation and Exclusions" Section of this booklet as well as the "Exclusions and Limitations" Subsections under the applicable Section of this booklet for more information. You will also want to check the "Definitions" Section which defines important terms of the Plan.

Q. You are required to cooperate fully with the Plan in submitting and processing your claim for benefits. This cooperation includes, but is not limited to, providing the correct and complete information to the Plan, notifying the Plan when any Third-Party may be liable

for all or any potion or your claim, and assisting the Plan in enforcing its rights of subrogation and reimbursement, and coordination of benefits.

R. Providers will be paid as follows:

1. In-Network Providers. For benefits charges incurred with in-network providers, the Plan will pay a discounted amount. These providers have agreed to accept payment from the Plan as payment in full, except for applicable Copayments, Deductibles, Coinsurance, maximum benefit limitations or other similar limitations under the Plan.

2. Out-of-Network Providers Treated as In-Network Providers. For benefit charges incurred with certain out-of-network providers in the circumstances described above in the "No Surprises Act" topic in the "Medical Coverage" section of this Summary Plan Description, the providers must, by law, accept payment from the Plan as payment in full, except for applicable copayments, deductibles, coinsurance, maximum benefit limitations, or other similar limitations under the Plan.

3. Out-of-Network Providers Generally. Benefits charges incurred with out-of-network providers in situations other than those described above (describing situations when certain out-of-network providers are treated as in-network providers under the No Surprises Act), the Plan will pay the Reasonable and Customary Charge or, if applicable, an amount separately negotiated with the non-participating provider. You will be responsible for applicable Copayments, Deductibles, Coinsurance, maximum benefit limitations or other similar limitations under the Plan and may be balance billed by the non-participating provider in accordance with applicable law.

17.2. PAYMENTS FOR THOSE ELIGIBLE FOR MEDICAL ASSISTANCE

Payment of benefits under this Plan with respect to any Eligible Individual will be made in accordance with any assignment of rights made by or on behalf of that individual as required by any applicable state plan for medical assistance which is approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of that Act. In enrolling an individual as an Eligible Individual, or in determining or making any payment of benefits for or on behalf of that individual, this Plan will not take into account the fact that the individual is eligible for or is provided medical assistance under an applicable state plan for medical assistance which has been approved under Title XIX of the Social Security Act. In any case in which this Plan has a legal liability to make payments of benefits for or on behalf of an Eligible Individual for items or services as to which payment has legally been made under the applicable state plan for medical assistance approved under Title XIX of the Social Security Act, such payment by this Plan will be made in accordance with any applicable state law which provides that the state has acquired a right to payment for the items or services with respect to the Eligible Individual.

17.3. COORDINATION OF BENEFITS PROVISION ("COB")

If you and/or your Dependents are covered by this Plan and another group health plan, benefits will be coordinated between the two (2) plans. This provision is commonly called "coordination of benefits" or "COB" and limits benefits payable under this Plan and other plans to one hundred percent (100%) of Covered Charges.

When medical expenses for a Dependent are covered by two (2) different group plans, you should file the claim with both plans. Make sure you provide all requested information to both plans. The claim departments will decide which plan is "primary" (pays benefits first) and which plan is "secondary" (pays eligible benefits not paid by the primary plan).

17.3.1. Definitions Applicable to Coordination of Benefit Provisions

For purposes of this Coordination of Benefits Section, the following terms will have the following meanings:

A. The terms "Plan," "Other Plan," or "Another Plan" as used in these COB provisions mean any of the following that provide medical or dental care or treatment, whether self-funded or funded through insurance. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no coordination of benefits among those separate contracts.

1. Group welfare benefit plan;
2. Group, Blanket or Franchise Insurance;
3. United Healthcare plans on a group basis;
4. Group practice plans;
5. Coverage under Government programs, or required or provided by statute (other than a welfare plan);
6. Group pre-payment plans;
7. Coverage required or provided by law;
8. Group auto insurance; and
9. Plans of other Hospital or medical service organizations on a group basis.

The term "Plan," "Other Plan," or "Another Plan" as used in these COB provisions does not include coverage provided under full Medicare coverage.

B. "This Plan" as used in these COB provisions means the part of the South Central Minnesota Electrical Workers Group Health Plan that provides benefits which are subject to coordination of benefits (COB).

C. "Allowable Expense" as used in these COB provisions means any Medically Necessary, Reasonable and Customary item or expense for medical care and services; a part of the expense must be covered under one of the plans for which the Eligible Individual is covered. When a Plan provides benefits in the form of furnishing services or supplies rather than cash payments, the reasonable cash value of each service or supply furnished will be deemed to be both an Allowable Expense and a benefit paid. The Trustees will not be required to determine the existence of any Plan or the amount of benefits payable under any Plan except This Plan, and the payment of benefits under This Plan will be payable under any and all other Plans only to the extent that the Trustees are furnished with information relative to such other Plans by the Employer or Employee or any insurance company or other organization or individual. If any of these expenses include

benefits provided under full Medicare coverage, the total of the Allowable Expenses will be reduced by the amount of those benefits.

D. "Claim Determination Period," as used in these COB provisions, means a Calendar Year during which the Employee is eligible under This Plan and Another Plan and Allowable Expenses are incurred that are eligible under This Plan and Another Plan.

17.3.2. Circumstances Under Which Coordination of Benefits Will Be Applied

Coordination of Benefits will be applied if the Eligible Individual has duplicate coverage with respect to the payment of all or a portion of a claim for benefits under any Other Plan. Coordination of Benefits applies to the Major Medical Expense Benefit. It does not apply to the Life Benefit.

17.3.3. Order of Benefit Payments

The order of benefit payments is determined as follows:

A. Both Covered as Employees Under This Plan. If you and your Spouse are both covered as Employees under this Plan and one of you has a claim, the Plan will coordinate benefits on the claim (two (2) claim forms must be submitted - one by you and one by your Spouse).

B. Other Plan – No COB. If you are covered under another group plan that does not have COB, the Other Plan is primary and This Plan is secondary.

C. Employee/Non-Employee. When the Other Plan does have COB, the Plan covering the individual (for whom the claim is filed) as an employee is primary, and the Plan covering the individual (for whom the claim is filed) other than as an employee is secondary.

D. Dependent Child/Dependent Spouse. If the individual (for whom the claim is filed) is covered under one Plan as a dependent child and another Plan as a dependent Spouse, the Plan covering the person as a dependent Spouse is primary and the Plan covering the individual as a dependent child is secondary. If the Other Plan does not have this rule, the Other Plan is primary.

E. Dependent Children. On claims for Dependent children, the following rules apply:

1. Parents Not Legally Separated or Divorced or Parents Living Together. With respect to claims filed on behalf of a Dependent child of parents who are not legally separated or divorced:

a. *Birthday Rule*. The Plan covering the parent whose birthday comes first in the year will pay first and the Plan covering the parent whose birthday comes later in the year will pay second (the year of birth does not count). For example, if your birthday is in September and your Spouse's birthday is in May, your Spouse's Plan will pay benefits on your children's claims first and This Plan will pay second;

b. *Same Calendar Day Date of Birth*. The benefits of a Plan which covers the individual as a dependent of an individual whose date of birth, excluding year of birth, occurs on the same calendar day, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other individual for a shorter period of time; and

c. *Other Plan* - No Birthday Rule. If your Spouse's plan does not have this "birthday rule," resulting either in each determining its benefits before the other or in each determining its benefits after the other, the rules of your Spouse's plan will govern the order of benefit payments on your children's claims.

d. *Divorced, Legally Separated, or Never Married and Not Living Together.* With respect to claims filed on behalf of a Dependent child of parents who are legally separated or divorced or do not live together:

(i) Court Decree. If there is a Qualified Medical Child Support Order ("QMCSO") which established financial responsibility for medical and health care expenses of a Dependent child, the Plan covering the parent who has that responsibility will pay first and the Plan covering the other parent will pay second. If the QMCSO states both parents are responsible for the Dependent child's medical and health care expenses, or if the QMCSO states both parents have joint custody without specifying one parent has responsibility for health care expenses or coverage, the provisions of subparagraph (i) above will determine the order of benefits;

(ii) Parental Custody Without Remarriage. If there is no such QMCSO, and the parent with custody has not remarried, the Plan covering the parent who has custody of the child will pay first and the other parent's Plan will pay second; and

(iii) Parental Custody With Remarriage. If there is no such QMCSO, and the parent with custody of the child has remarried, benefits for the child will be determined as follows: the Plan covering the parent who has custody will pay first, the Plan covering the Spouse of the parent who has custody (the step-parent of the child) will pay second, and the Plan covering the parent without custody will pay last.

F. Parents Both Covered as Employees Under This Plan. If both you and your Spouse are covered as Employees under This Plan, claims for your Dependent children will be coordinated, but two (2) claim forms must be submitted.

G. Dependent Child Who is an Employee of This Plan. If a Dependent child is covered under This Plan as an Employee, This Plan will not coordinate benefits on his or her claims. Benefits will be payable only as a claim as an Employee.

H. Active/In-Active Employee. The benefits of a Plan which covers an individual as an employee who is not retired or laid-off (or as that employee's dependent) will be determined before those of a Plan which covers that individual as a retired or laid-off employee (or as that employee's dependent). If the Other Plan does not contain this rule, this rule will be ignored.

I. Longer/Shorter Length of Coverage. If these rules for the order of benefit payments still do not clearly show which plan should pay first, the plan that has covered the individual for the longest period of time will pay first. The plan which has covered the individual for the next longest period of time will pay second, and so on.

17.3.4. Right to Release and Receive Information

As permitted by law, the Fund Office may, without the Eligible Individual's consent:

A. Obtain information from all Plans which might be involved;

B. Release to the Other Plans any information in this Plan's possession;

C. Reimburse the Other Plans, to the extent necessary, if it is determined that benefits have been paid by Another Plan which should have been paid by This Plan. That reimbursement will count as a valid payment under This Plan;

D. Obtain reimbursement from the Other Plan(s), or from the Employee if This Plan has paid benefits which should have been paid by any Other Plan(s). That reimbursement is a valid payment under the Plan(s); and

E. Obtain repayment of whatever amount is appropriate for the proper working of COB if payment from all sources exceeds one hundred percent (100%) of total expense, if the Plan determines that the one hundred percent (100%) of Eligible Expense was exceeded as a result of This Plan's payment.

17.3.5. Facility of Payment

A payment made under Another Plan may include an amount that should have been paid under This Plan. If it does, the Trustees have the right, exercisable in their sole discretion, to pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Trustees will not have to pay that amount again and will be fully discharged from liability under This Plan. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

17.4. COORDINATION OF BENEFITS WITH MEDICARE

17.4.1. For Retirees Eligible for Medicare

If you are a Retiree who is eligible for Medicare, This Plan will coordinate its benefits with Medicare Parts A & B when you have a claim. This means that Medicare will pay first, and This Plan will pay second based on amounts not paid by Medicare. If you are enrolled in the Medicare Part D Prescription Drug Program, you will not be covered by the Plan's Prescription drug benefit.

If you are a Retiree who is eligible for Medicare This Plan will apply these "Coordination of Benefits with Medicare" rules regardless of whether you have elected to enroll in Medicare or not. As a result, in order to ensure that you receive the maximum coverage, you should enroll in Medicare when you become eligible.

17.4.2. For Individuals under 65 (Employees and their Dependents only)

If an eligible family member is entitled to Medicare for reasons other than being sixty-five (65) or older, Medicare will usually pay first on the individual's claims and This Plan will pay second. However, federal law sometimes may require This Plan to pay first as follows:

A. If an eligible family member is Totally Disabled and is eligible for Medicare under the Medicare disability rules, This Plan may pay before Medicare pays. Contact the Administrative Manager to see if this rule applies.

B. Individuals eligible for Medicare by reason of End Stage Renal Disease ("ESRD") and eligible under This Plan through either Self-Contributions or Employer Contributions. In the event an Eligible Individual is eligible for Part A or Part B of Medicare solely because of End Stage Renal Disease, benefits will be provided subject to the following terms:

1. Benefits payable under This Plan will be limited to the Covered Expenses incurred during the initial thirty (30) consecutive months of treatment, beginning with the first month in which renal dialysis treatment is initiated providing a timely application was filed.

2. Benefits payable under This Plan beginning with the 31st month of treatment will be reduced by the amount of benefits paid or payable under Part A or Part B of Medicare.

3. Individuals eligible for Medicare by reason of Kidney Transplant and eligible under This Plan through either Self-Contributions or Employer Contributions. In the event an Eligible Individual is eligible for Part A or Part B of Medicare solely because of a Kidney Transplant, benefits will be provided subject to the following terms:

   a. Benefits payable under This Plan will be limited to the Covered Expenses incurred during the initial eighteen (18) consecutive months of treatment, beginning with the first month in which the individual could become entitled to Medicare, providing a timely application was filed.

   b. Benefits payable under This Plan beginning with the 19th month of treatment will be reduced by the amount of benefits paid or payable under Part A or Part B of Medicare.

This provision (for individuals under age sixty-five (65)) does not apply to Retirees or their Dependents.

17.5. COORDINATION OF BENEFITS WITH AUTOMOBILE, MOTORCYCLE, WATERCRAFT, OTHER RECREATIONAL VEHICLE OR OTHER MOTORIZED VEHICLE INSURANCE

This Plan will coordinate benefits with automobile, motorcycle, watercraft, and other recreational and motor vehicle insurance coverage as described in the following provisions:

A. Benefits payable under this Plan are not in lieu of those that would be payable under no-fault insurance and do not affect any legal requirement that an individual maintain the

minimum no-fault insurance or other insurance that provides medical or wage loss coverage within the jurisdiction in which that individual resides.

B. For any expenses arising from the maintenance or use of an automobile, motorcycle, watercraft, other recreational and motorized vehicle, no-fault insurance will calculate and pay its benefits first and This Plan will calculate and pay benefits second. The amount of benefits payable by This Plan will be coordinated so that the total amount paid does not exceed one hundred percent (100%) of the Allowable Expenses incurred.

C. Benefits that otherwise might be payable under no-fault insurance will not be payable by the Plan merely because no claim for no-fault benefits was filed. If an Eligible Individual fails to maintain the legally required no-fault automobile insurance within the jurisdiction in which the Eligible Individual resides, Plan benefits are not payable for amounts which the legally required minimum amount of no-fault insurance otherwise would have paid.

D. An individual injured in an automobile, motorcycle, watercraft, other recreational or motorized vehicle accident which is or should be covered by no-fault insurance must arbitrate any notice of discontinuance or non-payment of no-fault insurance or no benefits for said injuries will be payable under This Plan.

17.6. COORDINATION OF BENEFITS WITH OTHER TYPES OF INSURANCE

Coverage under this Plan is secondary coverage to any plan or policy of insurance which may pay medical expenses for a specific risk, including, but not limited to, any automobile policy, motor vehicle policy, motorized vehicle policy, homeowner's policy, or premises insurance policy.

This Plan may require that you show that you have made a reasonable effort to find out if there is another applicable insurance policy. Benefits that might otherwise be payable under another insurance policy will not be paid by This Plan merely because you have not made a claim under the other insurance policy.

17.7. EXCESS COVERAGE LIMITATION

All benefits payable under This Plan will be limited to being in excess of the benefits which are payable by any Other Plan or group insurance policy. An "excess policy" or "excess plan" pays benefits only in excess of benefits provided by any Other Plan or policy.

17.8. HOW TO APPLY FOR BENEFITS

17.8.1. Deadlines for Filing Claims

ALL CLAIMS SHOULD BE SUBMITTED WITHIN NINETY (90) DAYS AFTER YOU INCUR THEM. IN NO EVENT SHOULD YOU DELAY MORE THAN ONE YEAR - CLAIMS SUBMITTED OVER ONE YEAR AFTER THE DATE OF SERVICE WILL NOT BE ACCEPTED!

In response to COVID-19, the Plan adopted temporary rules in response to Department of Labor and Internal Revenue Service guidance providing extended timeframes related to filing a claim.

Starting on March 1, 2020, the deadline to file a claim was suspended during a "Tolling Period," which ends on the earlier of:

Sixty (60) days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the "Outbreak Period"); or

One (1) year from the date you were first eligible for relief from the deadline related to filing a claim. The earliest date that you were first eligible for relief from a deadline related to filing a claim was either:

1. March 1, 2020 for medical services provided on or before March 1, 2020, including periods during which a claim was required or permitted to be filed that began before March 1, 2020. To be in this window, the last day of the applicable deadline must have been on or after March 1, 2020; or

2. The date medical services were provided after March 1, 2020, but before March 1, 2021.

The calculation of your Tolling Period and relief from deadlines and suspension of certain requirements is fact-specific and is analyzed specifically as to you. The Tolling Period may not exceed one (1) year. If the medical services were provided prior to March 1, 2020, the number of days by which you are required to take action after the Tolling Period is shortened by the number of days between the date that medical services were provided and March 1, 2020.

17.8.2. Incomplete Claims

If you send a claim to the Administrative Manager and it cannot be processed because information is missing, you will receive a notice stating why the claim cannot be completed and what additional information is needed. It is your responsibility to send this information to the Administrative Manager. Approval or denial of a claim will be made within time frames listed below.

17.8.3. Claim Filing and Processing Procedures

To help the Administrative Manager process your claim as quickly as possible, please follow the steps listed below.

A. For Services Provided by a Member of the Preferred Provider Network. If you receive treatment and/or services from a Physician or Hospital that is a member of the Preferred Provider Network described at the front of this booklet, that provider will complete and file all necessary claim forms for you.

MAKE SURE TO BRING YOUR CURRENT ID CARD WITH YOU WHEN YOU RECEIVE SERVICES FROM THE PROVIDER SO THE PROVIDER HAS THE INFORMATION NECESSARY TO FILE YOUR CLAIM.

B. For Services Provided by Non-Members of the Preferred Provider Network. If you receive treatment and/or services from a Physician or Hospital that is not a member of that Preferred Provider Network, you must complete and submit claim forms as described below.

    1. Obtain the proper claim form.

a. If possible, call the Plan Administrator a few days before treatment is started or you are hospitalized to request a claim form, or

b. In case of an emergency, have the Hospital or a member of your family call the Plan Administrator as soon as possible so that a claim form may be requested. The individual who calls should be able to provide the following information:

i. Employee's name; and

ii. Employee's Social Security number.

2. Complete Your Portion of the Claim Form Completely and Accurately.

DON'T FORGET to provide: your Social Security number, name of other group health plans provided through employment of Spouse or Dependent children (this information is necessary for Coordination of Benefits), and if the claim is for a Dependent, the name of the Dependent.

a. Have your Physician complete the applicable portion of the form. BE SURE YOUR PHYSICIAN SHOWS A DIAGNOSIS ON THE CLAIM FORM. If your Physician provides his or her own claim form, you may submit it in place of the form provided by this Plan.

b. Attach all bills or receipts relating to the health service provided.

c. Make sure each bill clearly identifies the service (or supply), the fee, the patient's name and the date of service.

d. If the claim is for a Dependent, follow the first five (5) steps and be sure to complete that portion of the claim form referring to your Dependent.

e. ACCIDENT RELATED CLAIMS: If the claim you are submitting is the result of an accident, BE SURE TO COMPLETE THE ACCIDENT PORTION OF THE CLAIM.

C. For the Plan's Premium Credit Account Reimbursement Program. For a claim for reimbursement of Covered Expenses under the Plan's Premium Credit Account Reimbursement Program, follow these steps:

1. It is your obligation to file a claim if you believe you are entitled to reimbursement for expenses you have incurred. You may only file one claim for reimbursement in any calendar month. All claims for reimbursement must be received by the Plan Administrator on or before June 30th of the Calendar Year immediately following the Calendar Year in which the Covered Medical Expense was incurred.

2. Contact the Plan Administrator to obtain a Reimbursement Claim Form or to obtain instructions for filing your claim with the Plan.

3. Obtain an Explanation of Benefits (EOB) or itemized bill relating to each expense submitted that includes the name and contact information of the service provider. You must provide an EOB or itemized bill for each expense along with your Reimbursement Claim Form. Claims submitted without an EOB or itemized bill will

not be reimbursed. You will also be required to provide information regarding the date(s) of service, a short description of the claim, a claim total, and the name of any Dependent(s) for whom expenses were incurred on the Reimbursement Claim Form.

4. Send the Reimbursement Claim Form and EOB(s) or itemized bill(s) to the Administrative Manager at:

Wilson-McShane Corporation
1330 Conway Street, Suite 130
St. Paul, MN 55106

D. For the Plan's Weekly Income Disability Benefit. If you are disabled and are applying for the Weekly Income Disability Benefit, obtain the proper claim form from the Fund Office. Make sure the Physician has completed the applicable portion of the claim form; otherwise, payment of benefits will be delayed. During your disability, you will periodically be asked to complete a supplementary statement to help determine your continued eligibility for this benefit. This form must be completed by you and your Physician.

17.8.4. Proof of Loss

If the Plan provides for periodic payment for a continuing loss, written proof of loss must be given to the Plan Administrator within ninety (90) days after the end of each period for which the Plan is liable. For any other loss, written proof must be given within ninety (90) days after the loss. If it was not reasonably possible to give written proof in the time required, the Plan will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than one year from the time specified unless the claimant was legally incapacitated.

17.8.5. Time of Payment of Claims

After the Administrative Manager receives written proof of loss acceptable to the Plan, it will pay the weekly income benefit disability then due for disability. Benefits for any other loss covered by this Plan will be paid as soon as the Administrative Manager receives acceptable written proof of a payable claim.

17.8.6. Benefits Payable

A given service or supply may be eligible under more than one type of benefit of this Plan. However, total benefits paid under this Plan will never exceed actual expense incurred.

17.8.7. Payment of Claims

Benefits will be paid to the Employee. Any benefits unpaid at death will be paid either to the Employee's estate or, at the option of the Administrative Manager, under "Facility of Payment" (as described below.) The Administrative Manager can pay all or a part of any benefits provided for health care services to the provider if the Employee so directs in writing.

17.8.8. Facility of Payment - For All Benefits Other Than Life Benefits

If benefits are payable to the Employee's estate, the Administrative Manager can pay up to $1,000.00 of benefits to someone related to the Employee by blood or marriage whom the

Administrative Manager deems to be entitled to the benefits. If the Employee while living, is physically, mentally, or otherwise incapable of giving a valid release for any payment, the Administrative Manager can pay up to $1,000.00 of benefits to someone related to the Employee by blood or marriage, or to any individual or institution which has assumed financial responsibility for the affairs of the Employee.

17.8.9. Completed Claim Forms

Forward Completed Claim Forms and All Related Bills to the Administrative Manager:

Wilson-McShane Corporation
1330 Conway Street, Suite 130
St. Paul, MN 55106

17.9. INITIAL CLAIM REVIEW PROCEDURES

17.9.1. Urgent Care Claims

An Urgent Care Claim is one in which the application of the non-urgent care time frames could seriously jeopardize the life or health of the Eligible Individual or the ability of the Eligible Individual to regain maximum function or would subject the Eligible Individual to severe pain without the treatment that is the subject of the claim.

If you have an Urgent Care Claim, the Plan is required by federal law to inform you within seventy-two (72) hours of you submitting the claim to the Plan whether the Plan will treat your claim as a Covered Expense under the Plan. However, if you do not provide the Plan with sufficient information to determine whether benefits are payable under the Plan, the Plan will notify you within twenty-four (24) hours of its receipt of the claim concerning the need for additional information. You then have forty-eight (48) hours to provide the information required by the Plan. If you supply the information, the Plan then has forty-eight (48) hours in which to inform you whether the claim will be a Covered Expense under the Plan. In any event, if you fail to follow the Plan's rules for filing an urgent care claim, the Plan will notify you of the failure (and the proper filing procedure) within twenty-four (24) hours after the failure.

17.9.2. Claims Requiring Preauthorization (also called Pre-Service Claims)

Pre-Service Claims are those claims for which your receipt of a benefit from the Plan is conditioned, in whole or in part, on approval from the Plan prior to you receiving the medical care.

If the Plan states that a procedure requires preauthorization before it will be treated as a Covered Expense, you must submit the claim or the suggested course of treatment to the Plan Administrator well in advance of the service or treatment being performed. When you file a claim for which preauthorization is required, the Plan will notify you if the claim is authorized within fifteen (15) days of the Plan receiving the claim from you. If the Plan needs additional time in which to determine whether the claim is a Covered Expense, it can extend its determination for up to an additional fifteen (15) days as long as the Plan notifies you of its need for an extension within fifteen (15) days of the Plan receiving the claim. If the Plan's need for the extension is due to your failure to provide the Plan with all the information it needs to process the claim, you will have forty-five (45) days after the Plan asks for additional information in order to give the additional information to the Plan. If you failed to follow the Plan's procedures for filing the claim, the Plan will notify you of this failure within five (5) days (or within twenty-four (24) hours in the case of a claim involving urgent care) of receiving the claim.

Waiver of Prior Approval Requirements. The Plan will waive its prior approval requirements for urgent care claims for services that would otherwise be covered under the Plan. Even so, you or your medical provider must notify the Plan as soon as reasonably possible after the emergency medical care or treatment is provided, and the Plan will only pay the Reasonable and Customary charge for services determined to be Medically Necessary.

17.9.3. Concurrent Care Claims

A Concurrent Care Claim is a claim involving an ongoing course of treatment to be provided over a period of time and for which the Plan is reducing or terminating the treatment before the end of the scheduled treatment.

If the Plan reduces or terminates treatment before the end of the course of treatment, it will notify you far enough in advance of the termination or reduction in treatment to allow you to appeal the Plan's decision to the Plan and to receive an appeal decision before the reduction or termination. If you request to extend the treatment, the Plan will notify you within twenty-four (24) hours if the claim involves urgent care.

17.9.4. Disability Claims

A Disability Claim is a claim for disability benefits under the Plan.

The Plan will notify you of a Disability Claim denial within forty-five (45) days of receiving your claim. The Plan may extend this deadline up to thirty (30) days if the extension is due to matters beyond the Plan's control as long as the Plan provides you with written notice of the reason for the extension (and the expected decision date) within forty-five (45) days after receiving the claim. If, prior to the end of the thirty (30) day extension period, the Plan determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional thirty (30) days, provided the Plan notifies you, prior to the expiration of the first thirty (30) day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision. Any notice of extension will explain the standards for receiving the benefit, the unresolved issues preventing a claim decision, and the additional information needed to resolve those issues; and you will have you forty-five (45) days to provide the specified information.

17.9.5. All Other Medical Claims (also called Post-Service Claims)

If the Plan denies coverage for a medical claim, it will do so within thirty (30) days of the Plan's receipt of the claim from you or your provider. In certain situations, the Plan may extend this by an additional fifteen (15) days. If it does, it will notify you of the extension within the original thirty (30) days, will tell you the reasons for the extension, and when the Plan expects to make a decision on your claim. If the extension is needed because you failed to submit the necessary information to the Plan, the Plan will tell you of the information it needs and will give you forty-five (45) days to provide the needed information to the Plan.

17.9.6. Claim Denials

If your claim is partly or completely denied, the Plan's claim denial notice will be in writing and will:

A. Tell you the specific reasons your claim was denied;

B. Refer to the specific Plan provisions) on which the denial was based;

C. Describe any additional material or information for you to perfect the claim and an explanation of why the material or information is necessary;

D. Describe the Plan's review procedures and the time limits for these procedures (which are also stated below) and state that you have a right to bring a civil action under Section 502(a) of ERISA if any claim appeal that you might file is ultimately denied;

E. If an internal rule was relied upon by the Plan in making the decision, either provide a copy of the rule or state that you can obtain a copy of the rule, upon request and free of charge, from the Plan;

F. If the claim denial was based on a Medical Necessity or Experimental treatment or similar exclusion or limit, either provide an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) or state that you can obtain that explanation, upon request and free of charge, from the Plan;

G. State that the claimant has the right to receive, upon request and free of charge, reasonable access and copies of all documents, records, and other information relevant to the claim; and

H. If the claim is an urgent care claim, describe the expedited review process applicable to urgent care claims (which is also discussed above).

17.10. EXTERNAL REVIEW PROCEDURES

The Plan must implement an external review process for certain adverse benefit determinations involving items and services within the scope of the surprise billing and cost sharing protections of Sections 716 and 717 of ERISA and the regulations issued thereunder, as provided by the No Surprises Act, within the Consolidated Appropriations Act, 2021 (the "Surprise Billing Provisions," described below).

The Plan's external review process is limited to the review of adverse benefit determinations involving consideration of whether the Plan is complying with the Surprise Billing Provisions. Under the Surprise Billing Provisions, the Plan must generally cover as in-network any out-of-network Emergency Services, non-Emergency Services furnished to you by an out-of-network provider at a Participating Health Care Facility, and out-of-network Air Ambulance Services, subject to any other terms and conditions stated elsewhere in this Summary Plan Description, the Consolidated Appropriations Act, 2021, or the regulations issued pursuant to that act. Generally, under the Surprise Billing Provisions, the cost sharing requirements for these specific out-of-network items and services will be no greater than would apply if the items and services were provided by in-network providers, and cost sharing paid by you for these items and services will apply in the same manner as if the items and services were provided by in-network providers.

The Plan must provide benefits pursuant to an independent review organization ("IRO") decision without delay and regardless of whether the Plan intends to seek a judicial review of the external review decision and unless or until there is a judicial review otherwise.

A. Standard External Review

1. Request for External Review. You may file a request for external review of an adverse benefit determination involving consideration of whether the Plan is complying with the Surprise Billing Provisions within four months after the date you

receive notice from the Plan of an adverse benefit determination or final internal adverse benefit determination involving the Surprise Billing Provisions.

2. Preliminary Review.

   i. The Plan must complete its preliminary review within five business days following receipt of the external review request to determine whether:

      a. You were Covered Under the Plan at the time the health care item or service in question was requested, or in the case of a retrospective review, if you were Covered Under the Plan at the time the health care item or service was provided;

      b. The adverse benefit determination or final adverse benefit determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan and involves consideration of whether the Plan is complying with the Surprise Billing Provisions;

      c. You have exhausted the Plan's internal appeal process, unless you are not required to do so under the appeals rules; and

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

   ii. Within one business day of completing its preliminary review, the Plan will notify you in writing if:

      a. Your request is eligible for external review;

      b. Your request is complete, but it is not eligible for external review, in which case the Plan will provide you with the reasons it has determined that you are ineligible for external review, along with the contact information for the Department of Labor's Employee Benefits Security Administration (toll-free (866) 444-3272)); or

      c. Your request is not complete, in which case the notice will describe the missing information and materials needed to make the request complete, in which case you may revise your complaint within the four-month external review filing period or within 48 hours after receipt of the notice, whichever is later.

3. Referral to IRO. If your request is eligible for external review, the matter will be assigned to an IRO that is accredited by URAC or by a similar nationally recognized accrediting organization to conduct the external review. The Plan has contracted with three IROs and rotates external review assignments among them. The IRO will be required to:

   i. Timely notify you in writing concerning your request's eligibility and acceptance for external review and provide you information on submitting additional information;

ii. Use legal experts, where appropriate, to make coverage determinations under the terms of the Plan;

iii. Notify you of your right to submit additional information in writing for the IRO to consider in making its decision; and

iv. Notify the Plan of and provide to the Plan, within one day of receipt, any additional information you provide regarding your claim appeal, in which case if the Plan reverses its denial and provides coverage or payment based on this additional information, then the external review can be terminated.

4. Timely Review All Information and Documentation. In reaching its decision, the IRO will review the claim de novo and will not be bound by any prior decisions or conclusions reached during the Plan's internal claims review and appeals procedures. In addition to all of the information and documents timely received, to the extent the information or documents are available and the IRO considers them appropriate, the IRO will consider the following in reaching a decision:

i. Your medical records;

ii. The attending health care professional's recommendation;

iii. Reports from appropriate health care professionals and other documents submitted by the Plan, you, and your treating provider;

iv. The terms of the Plan to ensure that any decision reached is not contrary to the Plan's terms unless the terms are inconsistent with law;

v. Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government or national or professional medical societies, boards, and associations;

vi. Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or applicable law; and

vii. To the extent the final IRO decisionmaker is different from the IRO's clinical reviewer, the opinion of the IRO's clinical reviewer after considering the information described in this notice, to the extent the information or documents are available and the clinical reviewer considers such information or documents appropriate.

5. Written Notice of IRO's Final Decision. The IRO will provide written notice of its final external review decision to you and the Plan within 45 days after the IRO receives the initial request for external review. The IRO's notice of its decision will contain:

i. A general description of the reason for the request for external review, including the date(s) of service, the health care provider, the claim amount,

the diagnosis and treatment codes and their corresponding meanings, and the reason for the previous denial;

ii. The date the IRO received the assignment to conduct the external review and the date of the IRO's decision;

iii. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, that the IRO relied on in making its decision;

iv. A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

v. A statement that judicial review may be available to you; and

vi. Current contact information, including a phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

6. Maintaining Records. After the IRO reaches its final external review decision, the IRO will maintain records of all claims and notices associated with the external review process for six years. The IRO must make all such records available for examination by you, the Plan, and any state or federal oversight agency, upon request, except if such disclosure would violate state or federal privacy laws.

7. Reversal of Plan's Decision. The Plan, upon receipt of a notice that a final external review decision reversing the adverse benefit determination or final adverse benefit determination, will immediately provide coverage or payments for the claim.

B. **Expedited External Review**

1. Request for Expedited External Review. The Plan will allow you to make a request for an expedited external review at the time you receive:

i. An adverse benefit determination involving consideration of whether the Plan is complying with the Surprise Billing Provisions if it involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal;

ii. A final internal adverse benefit determination involving consideration of whether the Plan is complying with the Surprise Billing Provisions if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or jeopardize your ability to regain maximum function; or

iii. A final internal adverse benefit determination involving consideration of whether the Plan is complying with the Surprise Billing Provisions if it concerns an admission, availability of care, continued stay, or health care

item or service for which you received Emergency Services, but you have not been discharged from a facility.

2. Preliminary Review. Immediately upon receipt of a request for an expedited external review, the Plan will determine whether the request meets the reviewability requirements and send written notice to you regarding whether you are eligible for an expedited external review.

3. Referral to IRO. Upon determining that a request is eligible for expedited external review, following the preliminary review, the Plan will assign an IRO and provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO as expeditiously as possible, including but not limited to, by email, telephone, or fax.

4. Review of Documents. In reaching its decision, the IRO will consider your medical records and other documents to the extent appropriate.

5. Notice of Final External Review Decision. The IRO will provide notice of its final expedited external review decision as expeditiously as possible 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.

The decision of the IRO will be binding on the Plan as well as you, except to the extent other remedies are available under federal or state law.

17.11. BINDING DECISIONS

Decisions on review, including, if applicable, external review, are binding upon all persons dealing with the Plan or claiming any benefit under the Plan, except to the extent that such decision may be determined to be arbitrary or capricious by a court or arbitrator having jurisdiction over such matter. Note that if your claim for benefits is denied, no lawsuit or other action against the Plan or its Trustees may be filed until the review of the matter under the ERISA mandated review procedure set forth in this Article has been completed.

17.12. ASSIGNMENT OF BENEFITS AND APPOINTING AN AUTHORIZED REPRESENTATIVE TO ACT ON YOUR BEHALF

You or your Spouse, in most cases, can assign the right to receive payment for Covered Medical Expenses the Plan has determined to be payable to Physicians, ambulance services, laboratories, etc. This means that you sign a form that tells the Administrative Manager to pay the Physician, ambulance service, laboratory, etc. directly instead of to you. If an assignment is made, payment will be made as you have directed to the provider. This is true for claims where you use an In-Network Provider, as well as a non-participating provider located outside of the geographic area of the United Healthcare Network Service Area. The Plan will not make payments to you if the benefits have been properly assigned to a provider. However, there may be circumstances where the Plan cannot accept assignments to a provider if the provider is a non-participating provider located within the geographic area of the United Healthcare Network Service Area.

Neither you, nor any Dependent, including your Spouse, may assign any right to appeal benefit denials or any causes of action that may arise after the denial of benefits to any person or entity, including a provider.

Another individual may act on your behalf in pursuing a benefit claim or claim appeal, but only after you have delivered a signed letter to the Fund Office specifically naming the individual as your authorized representative. In any event, such a duly authorized representative will not have the right to make a personal appearance before the Board of Trustees or before any committee created by the Board of Trustees. Although you may appoint an authorized representative to act on your behalf, you may not assign your right to appeal or any causes of action you may have arising after the denial of benefits to that individual.

17.13. CLAIM APPEAL RIGHTS AND PROCEDURES

If all or part of your claim is denied after the Plan has received all necessary claim information, you have the right to appeal the decision and request a review of the claim.

The steps for appealing a claim denial are:

Step 1: Compose a claim appeal which explains why you believe your claim should be reviewed.

Step 2: Attach any additional information you think will help a favorable decision to be made on your claim.

Step 3: Return your completed appeal, along with any additional information you are submitting, to the Administrative Manager at the following address:

South Central Minnesota Electrical Workers' Family Health Plan
c/o Wilson-McShane Corporation
1330 Conway Street, Suite 130
St. Paul, MN 55106

17.13.1. Deadline for Filing Claim Appeals

Your claim appeal must be filed in writing and must be delivered to the Administrative Manager at the Fund Office within one hundred eighty (180) days after the date you received the claim denial. A claim appeal filed after that deadline will be denied for failure to file timely.

In response to COVID-19, the Plan adopted temporary rules in response to Department of Labor and Internal Revenue Service guidance providing extended timeframes related to filing claim appeals.

Starting on March 1, 2020, the deadline to file a claim appeal was suspended during a "Tolling Period," which ends on the earlier of:

Sixty (60) days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the "Outbreak Period"); or

One (1) year from the date you were first eligible for relief from a deadline related to filing a claim appeal. The earliest date that you were first eligible for relief from a deadline related to filing a claim appeal was either:

1. March 1, 2020 for claim denials or adverse benefit determinations occurring on or before March 1, 2020. To be in this window, the last day of the applicable deadline must have been on or after March 1, 2020; or

2. The date of a claim denial or adverse benefit determination that was after March 1, 2020, but before March 1, 2021.

The calculation of your Tolling Period and relief from deadlines and suspension of certain requirements is fact-specific and is analyzed specifically as to you. The Tolling Period may not exceed one (1) year. If the claim denial or adverse benefit determination occurred prior to March 1, 2020, the number of days by which you are required to take action after the Tolling Period is shortened by the number of days between the date of the claim denial or adverse benefit determination and March 1, 2020.

17.13.2. Claim Appeal Rights Under Federal Law

When appealing a claim, you have certain rights under federal law. These include:

A. You will have the opportunity to submit written comments, documents, records and other information relating to the claim but will not have the right to make a personal appearance before the Board of Trustees or any committee created by the Board of Trustees.

B. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

C. The review by the Plan will take into account all comments, documents, records, and other information submitted by you related to your claim, whether or not the information was submitted or considered in the initial benefit determination.

D. The review will be conducted by the Board of Trustees (or by a committee of Trustees appointed to consider claim appeals). The review will not be conducted by the individual who made the initial claim denial or by a subordinate of that individual, and the review will not afford deference to the initial claim denial.

E. If the appeal relates to a claim denial that was based at least in part on a medical judgment (including a judgment about whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate), the Trustees will consult with a healthcare professional who is trained and experienced in the field of medicine involved in that medical judgment and who was not consulted in connection with the initial claim denial and who is not the subordinate of anyone so consulted. Upon request, the Plan will identify any healthcare professional that the Trustees consulted in relation to the claim.

F. If the appeal involves a claim for urgent care, the request for an expedited appeal can be submitted orally or in writing, and all information will be transmitted between you and the Plan by telephone, fax, or similar method, including the appeal decision.

17.13.3. Applicable Time Frames for Deciding Claim Appeals

The applicable time frames for deciding Claim Appeals are as follows:

A. Urgent Care Claims - If your appeal is for an urgent care claim (defined above), the Plan will review your appeal and notify you of its decision with seventy-two (72) hours of the time you file the appeal with the Plan.

B. Preauthorization (Pre-Service) Claims - If your appeal is for a denial of a claim requiring preauthorization, the Plan will notify you of its decision on appeal within thirty (30) days of the Plan's receipt of your appeal.

C. All Other Claims - For all other claims, the Board of Trustees will review your appeal at its next regularly scheduled meeting. If your appeal was received by the Plan Administrator within fifteen (15) business days of the next regularly scheduled meeting, the Board of Trustees will review your appeal no later than the Board's second regularly scheduled meeting following the Plan Administrator's receipt of your claim appeal. You may request that the Board of Trustees expedite its consideration of your appeal by indicating as such in your written claim appeal request. If special circumstances require a further extension of time for processing, the Plan Administrator will notify you of the extension in writing (describing the special circumstances requiring the extension and the expected decision date) before the extension begins. The Board will also review the appeal no later than their third regularly scheduled meeting after the Plan Administrator receives your appeal.

Upon receiving such request, the Board of Trustees may, at their sole discretion, review your appeal earlier than the time frames described above.

Once your appeal is reviewed, the Plan will notify you of the appeal decision by the Plan within five (5) days.

17.13.4. Claim Appeal Denial

If your appeal is partly or completed denied, the Plan's appeal denial notice will be in writing and will:

A. Tell you the specific reason or reasons for the denial of the appeal;

B. Refer to the specific Plan provision(s) on which the denial is based;

C. State that you have the right to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim;

D. State that you have the right to bring a civil action under Section 502(a) of ERISA;

E. If the Plan relied upon an internal rule in denying the appeal, either provide a copy of the rule or state that you can obtain a copy of the rule, upon request and free of charge, from the Plan; and

F. If the appeal was denied based on a Medical Necessity or experimental treatment or similar exclusion or limit, either provide an explanation of the scientific or clinical judgment

for the determination (applying the terms of the Plan to your medical circumstances) or state that you can obtain that explanation, upon request and free of charge, from the Plan.

17.14. CIRCUMSTANCES WHICH MAY RESULT IN DENIAL OR LOSS OF BENEFITS

The Trustees or their duly appointed representatives are authorized to deny payment of a claim, and the reasons for denial may include one or more of the following:

A. The individual on whose behalf the claim was filed was not eligible for benefits on the date the expenses were incurred.

B. The claim was not filed within the Plan time limits.

C. The expenses that were denied are not Covered Expenses or the expenses for which the claim was filed were not actually incurred.

D. The individual for whom the claim was filed had already received the maximum benefit allowed for that type of expense during a stated period of time, for example: a Calendar Year maximum benefit, a lifetime maximum benefit, etc.

E. No payment, or a reduced payment, was made because some or all of the expenses for which the claim was filed were applied against a Deductible.

F. A Third-Party (such as the driver or insurer of a car that caused an accident for which medical expenses were incurred) was responsible for paying the incurred medical expenses and you or your Dependent, whether or not a minor, did not comply with the subrogation provisions of the Plan.

G. Another plan was primarily responsible for paying benefits for the expenses (see the Section on Coordination of Benefits).

H. The Trustees amended the Plan eligibility rules or decreased Plan benefits.

I. The Trustees reduced or temporarily suspended future benefit payments to you or your Eligible Dependent in order to recover an overpayment of benefits previously made on your or your Dependent's behalf.

J. Your Employer terminated Contributions to the Plan, either because your Employer did not enter into a successor Collective Bargaining Agreement requiring Contributions to the Plan, or because the Participation Agreement providing for Contributions to the Plan was terminated.

K. The Usual and Customary amount of a covered claim has previously been paid in full.

L. The Plan of Benefits was terminated.

The preceding list is not an all-inclusive listing of the circumstances which may result in denial or loss of benefits. It is only representative of the types of circumstances, in addition to failure to meet the regular eligibility requirements that might cause denial of a claim for benefits. If you have any questions about a claim denial, contact the Plan Administrator.

17.15. EXTENSION OF BENEFITS

If the Employee is Hospital confined on the Employee's termination date or receives medical treatment, exams or surgery after the Employee's eligibility ends, the Plan will pay the same benefit that would have been payable had eligibility not ended, provided that all of the following requirements are met:

A. The claim would have been valid had eligibility not ended;

B. The Employee is Totally Disabled when eligibility ends;

C. Confinement starts during the Total Disability for up to ninety (90) days following the date eligibility ends;

D. Treatment, exams or surgery takes place within ninety (90) days from the date eligibility ends;

E. The confinement, treatment, exam or surgery is needed to treat the Sickness or Injury causing Total Disability; and

F. The surgery, exam, service or confinement occurs during Total Disability.

SECTION 18 TERMINATION OF BENEFITS

SUMMARY

There are many different reasons why the Plan may terminate benefits to you and your Dependents. This Section of the document lists those reasons. If you do not understand why your benefits are discontinued, please call the Plan Administrator immediately.

18.1. BARGAINING EMPLOYEES, NON-BARGAINING EMPLOYEES AND RETIREES

A. Subject to the Continuation Coverage rules under COBRA, benefits for a Bargaining Unit Employee and all individuals covered through a Bargaining Unit Employee automatically end on the first of the following dates:

1. The date this Plan ends;

2. The first day of a month for which any required Contribution has not been timely made or the exhaustion of the Employee's Premium Credit Account;

3. The date the Employer of the Employee ceases to participate in this Plan;

4. The effective date of any change to this Plan to end a specific benefit, such as Retiree benefits;

5. The date coverage is effectively rescinded;

6. For failure to meet the eligibility requirements, at the end of the last day of the Benefit Month closest to the last Eligibility Month for which eligibility requirements were met;

7. If the Employee elects Continuation Coverage Under COBRA payments, coverage at the end of the last day of the 18th month (or 29th month for certain disabled Employees or event of early termination) and for which a correct and on-time Self-Contribution has been made for Continuation Coverage or on the date of occurrence of any of the events stated in the provisions entitled Termination of Continuation Coverage (under the Section of this booklet entitled "Continuation Coverage Under COBRA"), whichever occurs first;

8. If the Employee is covered under the Disability provisions, on the date that the Employee fails to meet the requirements of that provision;

9. The date an Employee leaves employment covered by the Plan with a Contributing Employer and then commences work for an employer, or as an employer, independent contractor, partner or sole proprietor that does not contribute to the Plan, but is engaged in the electrical contracting business in a geographic area covered by the Electrical Industry Health and Welfare Reciprocal Agreement, unless approved in advance by the Trustees;

10. The date the Employee enrolls in any branch of the military service of any country on a full-time basis and is eligible to receive any benefits under TRICARE with the exception of routine national guard training/exercises or, if the Employee elected

Military Continuation Coverage, on the date of occurrence of any of the events stated in the provisions entitled Termination of Military Continuation Coverage (under the Section of this booklet entitled "Military Service"), whichever occurs first; or

11. The last day of any month during which the Plan determines that the Employee has failed to enroll, re-enroll, or provide the Plan requested information related to the Employee or his or her Dependent as required by the Section entitled ELIGIBILITY.

B. Subject to the Continuation Coverage rules under COBRA, all other Employee's (including Retiree's) benefits automatically end on the first of the following dates:

1. The date this Plan ends;

2. The last day of the month for which any required Contribution has not been made or the exhaustion of the Employee's Premium Credit Account;

3. The date the Employer of the Employee ceases to participate in this Plan;

4. The effective date of any change to this Plan to end a specific benefit, such as Retiree benefits;

5. The date coverage is effectively rescinded;

6. The date of the Participation Agreement to which the Employer of the Employee is signatory and provides for Contributions to be made to the Plan terminates;

7. If the Employee elects Continuation Coverage Under COBRA payments, coverage at the end of the last day of the 18th month (or 29th month for certain disabled Employees) for which a correct and on-time Self-Contribution has been made for Continuation Coverage or on the date of occurrence of any of the events stated in the provisions entitled Termination of Continuation Coverage (under the Section of this booklet entitled "Continuation Coverage Under COBRA"), whichever occurs first;

8. The date an Employee leaves employment covered by the Plan with a Contributing Employer and then commences work for an employer, or as an employer, independent contractor, partner or sole proprietor that does not contribute to the Plan, but is engaged in the electrical contracting business in a geographic area covered by the Electrical Industry Health and Welfare Reciprocal Agreement, unless approved in advance by the Trustees;

9. The last day of any month during which the Plan determines that the Employee has failed to enroll, re-enroll, or provide the Plan requested information related to the Employee or his or her Dependent as required by the Section entitled ELIGIBILITY; or

10. The occurrence of any event delineated in Subsection F entitled; Termination of Benefits Coverage for Retirees and Their Dependents of the "RETIREE BENEFITS" Section.

18.2. DEPENDENTS

A. Subject to the Continuation Coverage rules under COBRA, a Dependent's benefits automatically end on the first of following dates:

1. The date this Plan ends;

2. The effective date of any change to this Plan to end a specific coverage, such as Dependent coverage;

3. The first day of a month for which any required Contribution has not been made;

4. The date the Dependent is eligible for coverage under the Plan as an Employee;

5. The date coverage is effectively rescinded;

6. The date the Employee ceases to be eligible for coverage under the Plan;

7. If the Dependent is making Continuation Coverage payments, coverage will terminate at the end of the first day of the 36th month for which a correct and on-time Self-Contribution has been made or on the date of occurrence of any of the events stated in the provisions entitled Termination of Continuation Coverage, whichever occurs first;

8. The date the Dependent enrolls in any branch of the military service of any country on a full-time basis and is eligible to receive any benefits under TRICARE with the exception of routine National Guard training/exercises;

9. The first day of the month following the date on which the Dependent ceases to meet the Plan's definition of a Dependent, except that if a child attains the specified age limit, and within thirty-one (31) days the Employee submits proof that the child:

   a. Is not able to work because of mental retardation or physical handicap;

   b. Is primarily dependent on the Employee for support, then the age limit will not apply as long as the child continues to meet these conditions; and

   c. Further proof of disability and dependency will be required not more often than once each year after the first two (2) years.

10. The last day of any month during which the Plan determines that the Dependent has failed to enroll, re-enroll, or provide the Plan requested information as required by the Section entitled, ELIGIBILITY; or

11. The occurrence of any event delineated in Subsection F entitled; Termination of Benefits Coverage for Retirees and Their Dependents of the "RETIREE BENEFITS" Section.

B. If dependency ceases due to the death of the Employee, then coverage for a Dependent who does not elect to Continuation Coverage under COBRA but elects to continue coverage by making Self-Contributions will terminate on the first of the following dates:

1. In the case of a Dependent Spouse, the date on which the Spouse is remarried;

2. In the case of a Dependent Spouse, the date the Dependent becomes covered under another group plan providing like benefits;

3. The date on which the Dependent no longer meets this Plan's definition of a Dependent unless the Dependent is entitled to enroll and does enroll and timely pays for COBRA Continuation Coverage;

4. The earlier of the last day of the thirty-six-month (36-month) period for which correct and on-time Self-Contributions have been made for Continuation Coverage under COBRA, or on the date of occurrence of any event stated in the "Continuation Coverage Under COBRA" Section in this booklet which causes that coverage to terminate;

5. The date on which the Trustees discontinue Dependent coverage for the class of Employees of which the Employee was a member immediately prior to death;

6. The end of the period for which any type of Contributions have been made, if required; or

7. The occurrence of any event delineated in Subsection F entitled; Termination of Benefits Coverage for Retirees and Their Dependents of the "RETIREE BENEFITS" Section.

18.3. RESCISSION OF COVERAGE

No individual or individuals seeking coverage on behalf of an Eligible Individual may engage in any fraudulent act, practice, or omission in connection with coverage under this Plan or make an intentional misrepresentation of material fact in connection with coverage under this Plan. If an Eligible Individual or an individual seeking coverage on behalf of an Eligible Individual engages in any such act, practice, omission, or misrepresentation, the Eligible Individual's coverage may be retroactively terminated or cancelled. Retroactive termination or cancellation includes, but is not necessarily limited to, the following:

A. Any loss, expense, or charge incurred as a result of such act, practice, omission, or misrepresentation; and

B. The individual for whom benefits were paid by the Plan will be required to reimburse this Plan for any claim erroneously paid by this Plan because of such act, practice, omission, or misrepresentation.

The Trustees of the Plan may treat coverage for such individual and those seeking benefits through such individual as void from the time the act, practice, omission, or misrepresentation occurred.

The following are examples of fraudulent acts, practices, or omissions or intentional misrepresentations of material fact that may result in the retroactive termination or cancellation of coverage. Intentionally or fraudulently failing to:

A. Timely update his or her enrollment status;

B. Report to this Plan:

1. His or her divorce;

2. His or her legal separation;

3. The death of a Dependent;

4. His or her loss of custody of a Dependent child; or

5. A Dependent's attainment of a limiting age.

C. Satisfy your notification responsibilities under this Plan, including those in the Subsection entitled "Notification Obligations" of this; or

D. Honor the Plan's rights of subrogation and reimbursement or otherwise failing to cooperate with the Plan, as set out in the Section entitled "General Plan Provisions."

This is not a complete list of acts, practices, and omissions that are considered fraudulent or a complete list of intentional misrepresentations of fact considered material. The requirements of this Subsection do not limit the Plan's ability to prospectively terminate an Eligible Individual's coverage.

18.4. NOTIFICATION OBLIGATION

An Eligible Individual must notify the Fund Office of any event or change in circumstances that affect:

A. Any Eligible Individual's eligibility for coverage under the Plan; or

B. Any Eligible Individual's eligibility for payment of any specific claim for benefits.

Notification must be provided to the Fund Office in writing within twenty (20) days of any such event or change in circumstances.

SECTION 19 GENERAL PLAN PROVISIONS

19.1. EXAMINATIONS

The Trustees have the right to have a Physician examine an individual for whom benefits are being claimed and to ask for an autopsy in the case of death. They also have the right to examine any and all Hospital or medical records relating to a claim.

19.2. FREE CHOICE OF PHYSICIAN

You have free choice of any Physician who meets this Plan's definition of a Physician.

19.3. GOVERNING LAW

This Plan is created and accepted in the State of Minnesota. All questions pertaining to the validity or interpretation of the Trust Agreement or the Plan or any questions concerning the acts and transactions of the Trustees or any other matter that affects the Trust Fund will be determined under federal law, where applicable federal law exists. If there is no applicable federal law, then the laws of the State of Minnesota will apply.

19.4. SUBROGATION AND REIMBURSEMENT

19.4.1. Introduction

The Plan has first priority subrogation and reimbursement rights if it provides benefits to or on behalf of an Eligible Individual which are the result of or related to an injury, occurrence, circumstance or condition for which the Eligible Individual has a right of redress against any Third-Party, for which the Eligible Individual claims a Third-Party is liable for or obligated to pay, for which the Eligible Individual has made a claim against any Third-Party, or for which a claim has been made against a Third-Party on behalf of the Eligible Individual or by virtue of a claimant's relationship to the Eligible Individual.

What do first priority rights of subrogation and reimbursement mean? They mean that if the Plan pays benefits or expenses which are, in any way, compensated by a Third-Party, such as an insurance company, the Eligible Individual agrees that when a recovery is made from that Third-Party, the Plan is fully reimbursed out of that recovery for the benefits the Plan previously paid. If the Eligible Individual, Eligible Individual's attorney, or other individual the Trustees deem necessary do not agree to the Plan's subrogation and reimbursement rules, benefits will not be paid.

For example, the subrogation and reimbursement rights may apply if an Eligible Individual is injured at work, in an automobile accident, at a home or business, in an assault or in any other way for which a Third-Party has or may have responsibility. If a recovery is obtained from a Third-Party, such as an insurance company, the Plan will be paid first and to the full extent of the benefits it paid. The Eligible Individual receives payment only after the Plan is fully reimbursed.

The rights of subrogation and reimbursement are incorporated into this Plan for the benefit of each Eligible Individual in recognition of the fact that the value of benefit provided to each Eligible Individual will be maintained and enhanced by enforcement of these rights. For purposes of subrogation and reimbursement, this Section (19.4) constitutes the full and complete Plan Document language and is not a Summary Plan Description (SPD).

19.4.2. Subrogation and Reimbursement – Rules for the Plan

The following rules apply to the Plan's first priority rights of subrogation and reimbursement:

A. Subrogation and Reimbursement Rights in Return for Benefits. In return for the receipt of benefits from the Plan, the Eligible Individual agrees that the Plan has first priority subrogation and reimbursement rights as described in this Subrogation and Reimbursement Section (Section 19.4). Further, the Eligible Individual, the Eligible Individual's attorney, or any other individual the Trustees may deem necessary will sign a form acknowledging the Plan's first priority subrogation and reimbursement rights prior to payment, or further payment, of benefits. Benefits may not be paid if an acknowledgment form is not on file for the Eligible Individual. Benefits may not be paid if the Eligible Individual, the Eligible Individual's attorney, or any other individual the Trustees deemed necessary refuses to sign the acknowledgment. The Plan's first priority subrogation and reimbursement rights to benefits paid prior to receipt of Plan notice of a subrogation and reimbursement right are not impacted if the Eligible Individual, the Eligible Individual's attorney, or any other individual the Trustees deem necessary refuse to sign the acknowledgment. The Plan has the sole discretion to determine, calculate, and/or itemize which benefits paid by the Plan are subject to the Plan's subrogation and reimbursement rights.

B. Constructive Trust or Equitable Lien. The Plan's first priority subrogation and reimbursement rights grant the Plan an equitable lien on the proceeds of any recovery obtained by the Eligible Individual from a Third-Party, whether by settlement, judgment or otherwise. The Plan's recovery operates on every dollar received by the Employee or Beneficiary from a Third-Party, and the Plan is reimbursed on a first dollar basis regardless of whether the Eligible Individual or any beneficiaries of the Eligible Individual have been made whole for his or her injuries. When a recovery is obtained, the recovery proceeds are held in trust by the Eligible Individual, his or her representative, or his or her attorney for the Plan. The Plan then imposes a constructive trust or equitable lien on the recovery proceeds and is paid on a first dollar basis to the full extent of its equitable subrogation and reimbursement rights. If the Eligible Individual fails to hold the recovery proceeds in trust or in any other way prejudices or adversely impacts the Plan's first priority subrogation and reimbursement rights, the Plan reserves the right to, among other things, pursue all available equitable actions and remedies, and will offset any future benefits payable under the Plan to the Eligible Individual or to any other individual eligible to receive benefits under the Plan based upon that individual's relationship to the Eligible Individual, regardless of whether the claims for benefits relate to the recovery. If the Plan initiates an equitable action for reimbursement, the Plan is seeking to enforce an equitable lien by agreement.

C. Plan Paid First. Amounts recovered or recoverable by or on the Eligible Individual's behalf are paid to the Plan first, to the full extent of its subrogation and reimbursement rights, and the remaining balance, if any, to the Eligible Individual. The Plan's subrogation and reimbursement rights come first even if the Eligible Individual is not "made-whole" or paid for all of his or her claims for damages. If the Plan's subrogation and reimbursement rights are not fully satisfied directly by a Third-Party, the Plan's right to reimbursement may be enforced to the full extent of any recovery that the Eligible Individual may have received or may be entitled to receive from the Third-Party regardless of how the recovery is characterized.

D. Right to Take Action. The Plan's rights of subrogation and reimbursement are equitable ones and apply to all categories of benefits paid by the Plan. The Plan and any other Eligible Individual can bring an action (including in the Eligible Individual's name) for specific performance, injunction, to impose an equitable trust, to obtain a declaratory judgment, to enforce an equitable lien by agreement, or any other equitable action necessary to protect its rights in the cause of action, right of recovery or recovery by an Eligible Individual. The Plan will commence any action it deems appropriate against an Eligible Individual, an attorney or any Third-Party to protect its subrogation and reimbursement rights. The Plan's subrogation and reimbursement rights apply to claims of eligible Dependents covered by the Plan regardless of whether such Dependent is legally obligated for expenses of treatment.

E. Applies to All Rights of Recovery or Causes of Action. The Plan's subrogation and reimbursement rights apply to any and all rights of recovery, colorable claims, or causes of action the Eligible Individual has asserted against a Third-Party, or any rights or recovery, colorable claims or causes of action which the Eligible Individual or any person acting on his or her behalf could assert against any Third-Party.

F. No Assignment. The Eligible Individual cannot assign any rights or causes of action they may have against a Third-Party to recover medical, disability or loss-of-time expenses without the express written consent of the Plan.

G. Full Cooperation. The Eligible Individual will cooperate fully with the Plan and do nothing to prejudice or adversely affect the Plan's subrogation and reimbursement rights. The Eligible Individual, whether personally or through an attorney, must periodically update the Plan on the Status of an action against a Third-Party. The time period between updates must not exceed 45 days. The Eligible Individual, his or her representative, or his or her attorney may not transfer his or her responsibility to update and communicate with the Plan regarding payment of the Plan's reimbursement or interest. The Eligible Individual or their Beneficiary must notify the Plan before executing any settlement agreement with a Third-Party, regardless of whether the settlement agreement purports to include or exclude the Plan's subrogation or reimbursement interest. Benefits payable under the Plan for the Eligible Individual and/or Dependents may be denied if the Eligible Individual or Beneficiary does not cooperate with the Plan, or future benefits may be offset in the event the Eligible Individual or Beneficiary does not fully reimburse the Plan.

H. Notification to the Plan. The Eligible Individual must promptly advise the Plan Administrator, in writing, of any claim being made against any individual or entity to pay the Eligible Individual for his or her Injuries, Sickness, or death.

I. Third-Party. Third-Party includes, but is not limited to, all individuals, estates, trustees, receivers, entities, federal, state or local governments, and insurers (including, but not limited to, liability, medical expense, wage loss, workers' compensation, premises' liability, no-fault, uninsured or underinsured motorist insurers), who reimburse, compensate or pay for a Eligible Individual's losses, damages, Injuries or claims relating in any way to the Injury, occurrence, conditions or circumstances leading to the Plan's payment of benefits. The Plan's rights of subrogation and reimbursement exist regardless of whether the policy of insurance is owned by the Eligible Individual.

J. Apportionment, Comparative Fault, Contributory Negligence, Equitable Defenses Do Not Apply. The Plan's subrogation and reimbursement rights include all portions of the Eligible Individual's claims regardless of any allocation or apportionment that purports to dispose

of any portion of the claims not otherwise subject to subrogation, including, but not limited to, any apportionment for pain and suffering, wage loss, partial or total disability, or to a Spouse for loss of consortium. The Plan's subrogation and reimbursement rights are not affected, reduced or eliminated by comparative fault, contributory negligence, the double-recovery rule, the make-whole or common-fund doctrines, or any other equitable defenses, or principles of unjust enrichment.

K. Attorneys' Fees. The Plan will not be responsible for any attorneys' fees or costs incurred by the Eligible Individual in any legal proceeding or claim for recovery, under the common-fund doctrine or any other legal theory unless prior to incurring such fees or costs, the Trustees agree in writing to pay all or some portion of attorneys' fees or costs. If any attorneys' fees or costs are awarded to the Eligible Individual's attorney from the Plan's recovery, the Eligible Individual will indemnify and reimburse the Plan for the attorneys' fees or costs.

L. Course and Scope of Employment. If the Plan has paid benefits for any injury which arises out of and in the course and scope of employment, the Plan's rights of subrogation and reimbursement will apply to all awards or settlements received by the Eligible Individual or to any individual as a result of the claimed injury, regardless of how the award or settlement is characterized and regardless of whether the Plan has intervened in the action. If attorneys' fees are awarded to the Eligible Individual's attorney from the Plan's recovery, the Eligible Individual will indemnify and reimburse the Plan for the attorneys' fees.

19.5. AMENDMENT, DISCONTINUANCE OR TERMINATION

The Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Board of Trustees may amend or terminate all or any part of the Plan at any time for any reason by resolution of the Board of Trustees or by any person or persons authorized by the Board of Trustees to take such action. If this Plan is discontinued or terminated benefits for Covered Expenses incurred before the termination date will be paid to Eligible Individuals as long as the Plan's assets are more than the Plan's liabilities. Full benefits may not be paid if the Plan's liabilities are more than its assets. Benefit payments will be limited to the funds available in the Trust Fund for that purpose. The Trustees will not be liable for the adequacy or inadequacy of those funds.

If there are any assets remaining after payment of all Plan liabilities, those assets will be used for purposes determined by the Trustees according to the Trust Agreement. Or the assets may be turned over to another employee benefit trust fund providing similar benefits. However, any use of those assets will be made only for the benefit of Eligible Individual who were Covered Under The Plan at the time of the Plan termination.

19.6. CLERICAL ERROR

Clerical errors or delays in keeping records for this Plan will not deny benefits which would otherwise have been granted, will not extend benefits which otherwise would have ceased, and will call for a fair adjustment of contribution and benefits to correct the error.

19.7. SEVERABILITY CLAUSE

If any provision or amendment to the Trust Agreement or the Plan should be determined or judged to be unlawful, the illegality will apply only to the provision in question. It will not apply to any other

provision of the Trust Agreement or the Plan unless the illegality would make it impractical or impossible for the Trust Agreement or the Plan to function.

19.8. TRUSTEE INTERPRETATION, AUTHORITY AND RIGHT

The Trustees have the sole authority to determine eligibility for benefits and construe the terms of this Plan Document and Summary Plan Description, the Trust Agreement, and any documents, rules, and procedures relating to the Plan. Their interpretation will be final and binding on all individuals dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees is challenged in court, it is the intention of the Trustees that the decision is to be upheld unless it is determined to be arbitrary or capricious.

See also the Important Notices at the front of this booklet for further information relating to the Trustees authority regarding the Plan.

19.9. PATIENT PROTECTION AND AFFORDABLE CARE ACT

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, imposes a number of requirements on group health plans, such as this Plan. The federal Departments of Health and Human Services, Treasury, and Labor have jointly issued regulations implementing some provisions of the Affordable Care Act. While the Trustees have taken care to ensure that the terms of the Plan comply with the requirements of the Affordable Care Act, a significant amount of ambiguity remains as to the requirements of the Affordable Care Act. The terms and provisions of the Plan will be construed, to the extent possible, to comply with the Affordable Care Act, or any amended version of the Affordable Care Act. If it is determined that any term or provision of the Plan cannot reasonably be construed to comply with the Affordable Care Act, or any amended version of the Affordable Care Act, that term or provision will not be enforced to the extent that it does not comply with the Affordable Care Act. A determination that a term or provision of the Plan cannot reasonably be construed to comply with the Affordable Care Act will not affect any other term or provision of the Plan.

19.10. CONSOLIDATED APPROPRIATIONS ACT, 2021

The terms and provisions of the Plan will be construed, to the extent possible, to comply with the Consolidated Appropriations Act, 2021, including the No Surprises Act. If it is determined that any term or provision of the Plan cannot reasonably be construed to comply with the Consolidated Appropriations Act, 2021, that term or provision will not be enforced to the extent that it does not comply with the Consolidated Appropriations Act, 2021. A determination that a term or provision of the Plan cannot reasonably be construed to comply with the Consolidated Appropriations Act, 2021, will not affect any other term or provision of the Plan.

19.11. GENETIC INFORMATION NONDISCRIMINATION ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act.

19.12. MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act.

19.13. WORKERS' COMPENSATION

This Plan is not in place of and does not affect any requirement for coverage under any workers' compensation law, occupational diseases law or similar law. Benefits that would otherwise be payable under the provisions of these laws will not be paid by the Plan merely because you did not file a claim for benefits under the rules of these laws.

19.14. COVERAGE UNDER ANOTHER HEALTH CARE PLAN

You must advise the Administrative Manager if you have coverage under any other health care plan. If this Plan pays primary benefits but later discovers that another plan should be responsible for paying primary benefits (and this Plan should be secondary), this Plan has the right to recover those benefits from you.

19.15. RIGHT OF RECOVERY

If the Plan pays more for a Covered Charge than is required under the terms and conditions of this Plan or for an expense that is not covered under this Plan, the Plan may recover the excess payment from any or all of the following:

A. The Eligible Individual who received the excess payment;

B. Any individual or provider to whom the payment was made;

C. Any insurance company, service plan, or any other organization which should have made payment; or

D. By offsetting payment of future benefits otherwise payable by this Plan until the overpayment is recovered.

SECTION 20 MEDICAL DATA PRIVACY & SECURITY

20.1. INTRODUCTION

HIPAA, the Health Information Technology for Economic and Clinical Health Act ("HITECH") and corresponding regulations govern the Plan's use and disclosure of your health information. While the Plan has always taken care to protect the privacy and security of your health information, the Plan adopted more formal procedures consistent with HIPAA. The information below discusses ways in which the Plan uses and discloses your health information.

Under HIPAA, the Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to tell you about:

A. The Plan's uses and disclosures of Protected Health Information ("PHI");

B. Your privacy rights with respect to your PHI;

C. The Plan's duties with respect to your PHI;

D. Your right to file a complaint with the Plan and the Secretary of the U.S. Department of Health and Human Services; and

E. The individual or office to contact for further information about the Plan's privacy practices.

20.2. THE PLAN'S USE AND DISCLOSURE OF PHI

The Plan will use PHI to the extent of and according to the uses and disclosures allowed by the Medical Data Privacy Regulations ("Privacy Regulations") and HIPAA Security Regulations ("Security Regulations") Final Omnibus Rule adopted under HIPAA and HITECH, including for purposes related to *Health Care Treatment, Payment, and Health Care Operations.*

The Plan will enter into agreements with other entities known as "Business Associates" to perform some of these functions on behalf of the Plan. Each Business Associate will be allowed to use and disclose only the minimum amount of PHI needed to perform the Business Associate's duties on behalf of the Plan. The Plan's agreements with its Business Associates will also meet the other requirements of the Privacy and Security Regulations.

20.2.1. Use of PHI for Treatment Purposes

Treatment includes the activities relating to providing, coordinating or managing health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your providers. As a health plan, the Plan is generally not involved in treatment situations but may, from time-to-time, release PHI to assist providers in your treatment.

20.2.2. Use of PHI for Payment and Health Care Operations

Payment includes the Plan's activities to obtain premiums, Contributions, Self-Contributions, and other payments to determine or fulfill the Plan's responsibility for coverage and providing benefits under the Plan. It also includes the Plan obtaining reimbursement or reimbursement for providing health care that has been provided. These activities include, but are not limited to, the following:

A. Determining eligibility or coverage under the Plan;

B. Adjudicating claims for benefits (including claim appeals and other benefit payment disputes);

C. Subrogation;

D. Coordination of Benefits;

E. Establishing Self-Contributions by individuals Covered Under the Plan;

F. Billing and collection activities;

G. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to covered persons' inquiries about payments;

H. Obtaining payment under stop-loss or similar reinsurance;

I. Reviewing whether claims are payable under the Plan, including whether they are Medically Necessary, Reasonable and Customary, or otherwise payable;

J. Reviewing coverage under the Plan, appropriateness of care, or justification of charges;

K. Utilization review, including but not limited to preauthorization, concurrent review and retrospective reviews;

L. Disclosing to consumer reporting agencies certain information related to collecting Contributions or reimbursement (the information that may be released is: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and

M. Reimbursement to the Plan. Health Care Operations can include any of the activities provided below. While the Plan does not currently use or release PHI for all of these activities, it may do so in the future to perform health care operations of the Plan:

1. Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines as long as general knowledge is not the primary purpose of these studies; population based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;

2. Reviewing the competency or qualifications of health care professionals; evaluating provider performance; accreditation, certification, licensing or credentialing activities;

3. Underwriting, premium rating and other activities relating to creating, renewing or replacing a health insurance contract (or reinsurance) or health benefits under the Plan;

4. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

5. Planning and development, such as conducting cost-management and planning related analyses relating to managing and operating the Plan (including formulary development and administration, development or improvement of methods of payment or coverage policies); and

6. Management and general administrative activities of the Plan, including, but not limited to:

   a. Managing activities related to implementing and complying with the Privacy Regulations;

   b. Resolving claim appeals and other internal grievances;

   c. Merging or consolidating the Plan with another plan, including related due diligence; and

   d. As permitted under the Privacy Regulations, creating de-identified health information or a limited data set.

20.3. OTHER USES AND DISCLOSURES OF PHI

The Privacy Regulations permit certain other uses and disclosures of your PHI. These include, for example, releasing PHI to personal representatives of deceased covered persons, releasing PHI for public health activities, releasing PHI for court proceedings, and releasing PHI for law enforcement and similar purposes. If the Plan releases PHI in any of these other permitted situations, it will do so according to the requirements of the Privacy Regulations.

The Privacy Regulations also permit the Plan to release PHI if it receives a valid written authorization from you. If the Plan receives a valid written authorization, the Plan will disclose PHI to the individual or organization you authorize to receive the information. This may include, for example, releasing information to your Spouse, to the pension plan, other retirement plans, vacation plan or similar plan for the purposes related to administering those plans. The sale or use of PHI for paid marketing also requires a valid, written authorization from you. Uses and disclosures of PHI not described in this Section and will only be made pursuant to your valid written authorization.

20.4. RELEASE OF PHI TO THE BOARD OF TRUSTEES

The Plan will disclose PHI to the Board of Trustees, which is considered the Plan Sponsor under the Privacy and Security Regulations. The Plan has received a certificate from the Board of Trustees that the Plan documents, including this Summary Plan Description, have been amended to incorporate the following provisions.

The Board of Trustees will receive and use PHI only for the Plan administration functions that the Trustees perform for the Plan. In addition, the Trustees will:

A. Not use or further disclose PHI other than as permitted or required by the Summary Plan Description or as required by law;

B. Ensure that any agents (such as Union business agents or employees of the Employers' Association), including subcontractors, to whom the Board of Trustees provides PHI

received from the Plan, agree to the same restrictions and conditions that apply to the Board of Trustees with respect to that PHI;

C. Not use or disclose PHI for employment-related actions and decisions unless authorized by the individual who is the subject of the PHI;

D. Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual who is the subject of the information;

E. Report to the Plan any PHI use or disclosure that is inconsistent with the allowed uses or disclosures of which it becomes aware;

F. Make PHI available to an individual who is the subject of the information according to the Privacy Regulation's requirements;

G. Make PHI available for amendment and incorporate any amendments to PHI according to the requirements of the Privacy Regulations;

H. Make available the PHI required to provide an accounting of disclosures;

I. Make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for the purposes of determining the Plan's compliance with the Privacy Regulations;

J. Return or destroy all PHI received from the Plan, if feasible, that the Trustees maintain in any form, and retain no copies of the PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and

K. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) that they create, receive, maintain or transmit on behalf of the Plan. The Trustees will report to the Plan any security incident of which it becomes aware.

20.5. TRUSTEE ACCESS TO PHI FOR PLAN ADMINISTRATION FUNCTIONS

As required under the Privacy Regulations, the Plan will give access to PHI only to the following individuals:

A. The Board of Trustees (including alternate Trustees if any are appointed in the future). The Plan will release PHI to the Trustees, and the Trustees will be able to use PHI, for purposes of hearing and determining claim appeals; making other determinations concerning claims payments; assisting covered persons with eligibility and benefit issues; Plan benefit design; amending, modifying and terminating the Plan; and Plan management issues.

B. The Trustees' agents, such as Union business managers and business agents, the Employers' Association, and their respective staffs, only to the extent reasonable to assist the Trustees in fulfilling their duties consistent with the above uses and disclosures of PHI.

The disclosure of electronic PHI is supported by reasonable and appropriate security measures to the extent the above noted personnel access electronic PHI.

20.6. NOTIFICATION OF A BREACH

As required by the Privacy Regulations and the Final Omnibus Rule, the Plan will notify you in the event the Plan (or a Business Associate) discovers a breach of unsecured PHI.

20.7. NONCOMPLIANCE ISSUES

If the individuals described above do not comply with this Summary Plan Description, the Board of Trustees will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

20.8. PLAN'S PRIVACY OFFICER AND CONTACT PERSON

As required by the Privacy Regulations, the Plan has named a Privacy Officer to oversee the Plan's compliance with the Privacy Regulations. The Plan has also named a Contact Person to help answer your questions concerning the Privacy Regulations and your PHI. You can also call the Contact Person if you have any complaints concerning the use or disclosure of your PHI. If you have any questions or complaints concerning your PHI, please contact the Administrative Manager and ask to speak with the Plan's Contact Person.

SECTION 21 HIPAA SECURITY

21.1. INTRODUCTION

The federal Department of Health and Human Services has adopted regulations governing the Plan's obligation to maintain the security of your health information. The regulations arose from HIPAA and work in conjunction with the Privacy Regulations. While the Plan has always taken care to secure your health information, regulations require the Plan to take some additional steps, in addition to those required by the Privacy Regulations, to maintain the electronic, physical and technical security of your PHI. The information below outlines the additional steps the Plan has taken to secure your PHI in compliance with the HIPAA Security Regulations.

21.2. POLICIES TO PROTECT PHI IN ELECTRONIC FORM

The Plan, along with the Administrative Manager, has implemented administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI in electronic form (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these regulations) created, received, maintained or transmitted on behalf of the Plan. The Trustees will report to the Plan any security incident of which they become aware.

21.3. BUSINESS ASSOCIATES

The Plan will enter into agreements with other entities known as "Business Associates" who perform functions as part of the administration of the Plan. The Plan's agreements with its Business Associates will require that the electronic, physical and technical security of your PHI in electronic form be maintained.

21.4. ACCESS TO PHI IN ELECTRONIC FORM FOR PLAN ADMINISTRATIVE FUNCTIONS

As indicated in the amendment covering the Privacy Regulations, the Plan may provide access to PHI to the Board of Trustees. Any such disclosures of your PHI in electronic form to the Board of Trustees are supported by reasonable and appropriate security measures. If any of the above noted personnel fail to comply with these provisions, the Board of Trustees will provide a mechanism for resolving issues of noncompliance.

21.5. IF YOU HAVE ANY QUESTIONS

The Administrative Manager is largely responsible for maintaining the security of your PHI in electronic form. The Administrative Manager has appointed a Security Officer for purposes of Security Regulations compliance. If you have questions regarding the security of your PHI in electronic form, you may contact the Security Officer through the Administrative Manager.

SECTION 22 YOUR RIGHTS UNDER ERISA

As an Eligible Individual in South Central Minnesota Electrical Workers' Family Health Plan, you are entitled to certain rights and protections under the ERISA. ERISA provides that all Eligible Individuals will be entitled to:

22.1. RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine, without charge, at the Administrative Manager's office and at other specified locations, such as worksites and Union halls, all documents governing the Plan, including insurance contracts and 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.

Obtain, upon written request to the Administrative Manager, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrative Manager may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Administrative Manager is required by law to furnish each Eligible Individual with a copy of this summary annual report.

22.2. CONTINUE GROUP HEALTH PLAN COVERAGE

Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting 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, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to twenty-four (24) months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for twelve (12) months eighteen ((18) months for late enrollees) after your enrollment date for coverage.

22.3. PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Eligible Individual, 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 Eligible Individuals. No one, including your Employer, your Union, or any other individual, 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.

22.4. ENFORCE YOUR RIGHTS

If your claim for a welfare benefit is denied or ignored, 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 a copy of Plan documents or the latest annual report from the Plan and do not receive them within thirty (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 you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decisions or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are 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 individual 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 is frivolous.

22.5. 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, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

SECTION 23 INFORMATION ABOUT YOUR PLAN

23.1. NAME AND TYPE OF PLAN

The name of your Plan is the South Central Minnesota Electrical Workers' Family Health Plan.

The Plan is a self-insured group health plan, which provides life, weekly income disability, mental health and chemical dependency, and major medical benefits.

23.2. SPONSORSHIP AND ADMINISTRATION

Your Plan is sponsored and administered by a joint labor-management Board of Trustees. The Board is divided equally between Trustees selected by the Union and by Trustees appointed by Contributing Employers. The Board of Trustees is the Plan Administrator of the Plan.

The names and addresses of the individual Trustees are listed in the front of this booklet. The address of the third-party Administrative Manager the Trustees have hired to help administer the Plan is:

Wilson-McShane Corporation
1330 Conway Street, Suite 130
St. Paul, MN 55106
(952) 851-5949 / (800) 535-6373

The Plan is maintained under Collective Bargaining Agreements between the Union and, respectively, the Minneapolis Chapter of the National Electrical Contractors Association, and the Limited Energy Association. Copies of the Collective Bargaining Agreements may be obtained by Eligible Individual upon written request to the Plan Administrator. Copies are also available for examination by Eligible Individual at the office of the Administrative Manager.

Eligible Individual may receive, from the Administrative Manager, upon written request, information as to whether a particular employer or union is a sponsor of the Plan and, if the employer or union is a Plan sponsor, the sponsor's address.

23.3. SERVICE OF LEGAL PROCESS

The Plan's agent for service of legal process is:

Mr. Martin C. Lasley
South Central Minnesota Electrical Workers' Family Health Plan
Wilson-McShane Corporation
1330 Conway Street, Suite 130
St. Paul, MN 55106

Service of legal process may also be made on any Trustee.

23.4. SOURCE OF CONTRIBUTIONS/PARTICIPATION

The Trust Fund receives Contributions from Employers who have entered into Collective Bargaining Agreements with any local union affiliated with the Union and are required to contribute to the Trust Fund the amounts of those Contributions as calculated according to a formula in the relevant Collective Bargaining Agreement which specifies a particular dollar amount to be

contributed for each hour of covered employment. The Trust Fund also receives Contributions from Employers who have Participation Agreements with the Trustees to provide coverage for their employees who are Non-Bargaining Unit Employees. In those cases, the Trustees will determine an Employer's rate of contribution when approving the Participation Agreement. Contributions are made monthly to the Trust Fund and enable Employees working under Participation Agreements to participate in the Plan.

Employees are entitled to participate in this Plan if they work under one of the Collective Bargaining Agreements or Participation Agreements and if their Employers make the required Contributions to the Fund on their behalf.

The Fund also receives Self-Contributions from Employees, Retirees, and Dependents for the purpose of continuing coverage under the Plan. In those cases, the Trustees determine the rate of contributions according to applicable law.

23.5. ACCUMULATION OF ASSETS/PAYMENTS OF BENEFITS

Employer Contributions and Employee, Retiree and Dependent Self-Contributions are received and held in the Trust Fund by the Trustees pending the payment of benefits, insurance premiums, and administrative expenses.

All benefits paid from this Plan are self-insured. In other words, the Plan does not rely on insurance contracts with health insurance companies to pay for your claims but rather pays claims directly to your service providers with money from the Trust Fund. Even so, the Plan does obtain stop-loss coverage on an individual and/or aggregate basis. Stop-loss insurance does not pay your claims but rather reimburses the Trust Fund if claims rise above a certain level.

23.6. PLAN/FUND YEAR

The financial records of the Trust Fund and the Plan are maintained on a 12-month fiscal year basis beginning on July 1 of each year and ending June 30 of each year.

23.7. PLAN NUMBER AND TRUST FUND IDENTIFICATION NUMBER

The Employer Identification Number (EIN) assigned to the Trust Fund by the Internal Revenue Service is 41-1305411. The Plan number the Trustees have assigned to the Plan is 001.

23.8. QUALIFIED MEDICAL CHILD SUPPORT ORDER ("QMCSO") PROCEDURES

Eligible Individuals can obtain, without charge from the Administrative Manager, a copy of the Plan's procedures concerning QMCSOs.

23.9. PREFERRED PROVIDER NETWORK DIRECTORY

A directory of the providers in the Plan's Preferred Provider Network is available to you at https://www.ibewlocal343.org/, when you become eligible under the Plan. A copy of the directory can also be obtained from United Healthcare.

23.10. WEBSITE

caremark.com (for mail order prescription drugs).

23.11. TELEPHONE NUMBERS

Fund Office	(952) 851-5949 or (800) 535-6373
CVS Caremark (Prescription Mail Order)	1- 866-818-6911
TEAM (Employee Assistance Program)	(651) 642-0182 or (800) 634-7710