SOUTH CENTRAL MINNESOTA ELECTRICAL WORKERS' FAMILY HEALTH PLAN

PLAN DOCUMENT
AND
SUMMARY PLAN DESCRIPTION

AMENDED AND RESTATED EFFECTIVE JANUARY 1, 2015

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 Plan Administrator, Alan Sturm & Associates, Inc., at (952) 835-3035 or 1-800-247-0401.

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 Plan Administrator at (800) 247-0401 or (952) 835-3035. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

HOW TO USE THIS BOOK

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.

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

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 resolution of alcoholism, chemical dependency,

mental and nervous disorders and other life issues)

The Plan provides an Employee Assistance Program through Blue Cross Blue Shield of Minnesota's Employee Assistance Program. Blue Cross 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 Blue Cross will address is contained in the Subsection entitled "Your Employee Assistance Program Provided Through Blue Cross Blue Shield of Minnesota" under the Section of this booklet entitled "Mental Health and Chemical Dependency Benefit."

Blue Cross's services are covered under the Plan 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 Blue Cross Blue Shield of Minnesota for help at (651) 662-0900 or 1-800-432-5155.** 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 under the Section of this booklet entitled "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 Blue Cross Blue Shield of Minnesota. Blue Cross provides a network of doctors and hospitals who have agreed to provide quality medical services to you and your Eligible Dependents. The network offers the Plan the opportunity to better manage and control its cost. Please remember, you have the choice of whether to obtain medical services in or out of the network.

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 Physician or a Hospital. 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. However, you do have the option to use providers outside the network. The Plan will still make payment to providers that are not part of the Blue Cross Blue Shield of Minnesota Network Service Area ("non-participating providers"). However, if you use a non-participating provider, you will have more out-of-pocket costs.

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 Physician or Hospital. 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 has authority to determine eligibility for the benefits described in this booklet and to interpret the terms of this booklet. 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 parties that the decision is to be upheld unless it is determined to be arbitrary or capricious. No Employer or Union nor any representative of any Employer or Union, in that capacity, is authorized to interpret the Plan, nor can any such individual act as agent of the Trustees. 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 Trustees, by the Plan Administrator.

Trustee Authority

The Board of Trustees 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 the participants and beneficiaries. 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 participant at the last address provided 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. For you to promptly receive this information, YOU MUST PROVIDE THE PLAN YOUR CORRECT ADDRESS FOR THE PLAN FILES.

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PHARMACY BENEFIT MANAGER

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TABLE OF CONTENTS

SCHEDULE OF BENEFITS

SUMMARY

This Schedule of Benefits provides you with a brief description of the limits that apply to each type of benefit provided by the Plan. Benefits are payable to Eligible Employees (and their Eligible Dependents) (as defined in the "Definitions") only for services described in this booklet that are Medically Necessary (as defined in the "Definitions") 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 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.

LIFE & WEEKLY DISABILITY BENEFITS

LIFE BENEFIT:	**$5,000**
WEEKLY INCOME DISABILITY BENEFITS:	
Maximum Loss-of-Time Benefit/ Weekly Disability Rate:	**$ 450**
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*****

MAJOR MEDICAL EXPENSE BENEFIT

Emergency Medical Program	**EFFECTIVE MARCH 25, 2014, THE EMERGENCY** *MEDICAL PROGRAM IS CLOSED TO NEW ENTRANTS** A lower-cost medical plan offered to Bargaining Unit Employees and their Eligible Dependents who are: (i) currently out of work; (ii) actively seeking work in the industry; and (iii) and who have exhausted his/her premium credit account (hour bank). **This Plan will *differ* from the regular Plan as follows:** • Life, disability and prescription drug benefits ***are not*** included; • The annual Deductible is $5,000 per Eligible Individual, $10,000 per Family Maximum; • Coinsurance is 75% / 25% coverage of Reasonable and Customary Covered Expenses; • Maximum out-of-pocket Coinsurance expenses are $10,000 per Eligible Individual per Calendar Year, $15,000 per Family Maximum per Calendar Year; and • Coverage under this lower-cost medical plan will not count towards your Retiree discount.
Provider Network	Blue Cross/Blue Shield of MN
Claim Form	No claim forms are required except for Loss-of-Time Benefit/Weekly Income Disability Benefit. **ASSIGNMENT OF BENEFITS TO BLUE CROSS / BLUE SHIELD OF MN PROVIDER IS AUTOMATIC.** **REMEMBER: YOU MUST SHOW YOUR I.D. CARD!**
Maximum Benefit Limits	
Lifetime Maximum for Non-Essential Health Benefits per Eligible Individual	$2,000,000
Annual Maximum for Essential Health Benefits per Eligible Individual	Plan year beginning July 1, 2012: $2,000,000 Plan year beginning July 1, 2013: Minimum amount permitted by law

Deductible (per Calendar Year)	$350.00 per Eligible Individual $700.00 per Family Maximum
Coinsurance	80% / 20% coverage of Reasonable and Customary Covered Expenses. *Each Eligible Individual will pay twenty percent (20%) of any Reasonable and Customary Covered Expense in excess of any applicable Copayments and Deductibles before the Plan will begin to pay benefits.* *Coinsurance for the following Covered Expenses **will not** be included in the maximum out-of-pocket expense:* • *Prescriptions*
Maximum out-of-pocket Coinsurance expense (per Calendar Year)	$2,000 per Eligible Individual $4,000 per Family Maximum *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.*
Copayments	Copayments are fixed dollar amounts Eligible Individuals must pay before receiving certain Covered Services such as urgent care, doctor office visits and prescriptions. Applicable Copayments for the various Covered Medical Expenses are provided below. ***Please note:** Copayments do not apply towards satisfaction of the Deductible or Maximum out-of-pocket Coinsurance amounts.*
Covered Medical Expenses	
The 80% / 20% Coinsurance coverage described above applies to any remaining Reasonable and Customary Covered Expense in excess of the applicable Copayments and Deductible, subject to the maximum out-of-pocket Coinsurance expense.	
Office Visits	$40.00 Copayment
Urgent Care Center	$40.00 Copayment.

Convenience Care Clinics	$10.00 Copayment. *Convenience Care Clinics provide services and treatment for basic illnesses such as ear aches, skin infections, strep throat, pink eye, and similar problems.*
Emergency care	$115.00 Copayment.
Chiropractic Care	$40.00 Copayment. ***Please Note: The maximum** Chiropractic Care benefit the Plan will pay per Calendar Year is $500.00.*
Physical Therapy, Speech Therapy and Occupational Therapy	$ 40.00 Copayment. ***Please Note:*** Physical Therapy - Pre-authorization is required when more than five (5) sessions of physical therapy are recommended per episode of care. Speech and Occupational Therapy - Pre-authorization is required before any episode of care for speech or occupational therapy.
Preventive Medicine	No Copayment. ***Please note**: The coverage specified below IS NOT subject to the Deductible, but IS subject to Coinsurance.* Well baby care - coverage is only applicable for Dependent children. Immunizations - coverage is only applicable to Eligible Individuals as recommended by the Department of Health and Human Services Centers for Disease Control and Prevention. Pap Smears and mammograms - are covered. Routine Physical Examinations - one examination every Calendar Year; coverage is only applicable for an Eligible Employee and the Eligible Employee's spouse. Prostate Specific Antigen (PSA) Test Benefit - coverage is only applicable to male Eligible Individuals forty (40) years of age and older; one procedure is covered per Calendar Year, unless there is a Clinical History of prostate disease. Colonoscopy Benefit - coverage is only applicable to Eligible Individuals forty (40) years of age and older; one procedure is covered every five (5) Calendar Years, unless there is a Clinical History of colon disease.

Hospital Services: Room and Board, (Semi-Private Max)	$ 50.00 Copayment.
Inpatient Doctor Calls and Inpatient Surgery Scheduled Outpatient Services including Outpatient Surgery Hospital & Physician, Surgery Charges	No Copayment, but subject to Deductible and Coinsurance.
Outpatient Hospital (Emergency Room) Physician and all other Emergency Room Charges	$115.00 Copayment.
X-Ray and Lab Work	No Copayment, but subject to Deductible and Coinsurance.
Miscellaneous Services: Durable medical equipment, skilled nursing facility, home health care, ambulance	No Copayment, but subject to Deductible and Coinsurance.
Private duty nursing, non-durable medical equipment, prosthetics, accidental dental	No Copayment, but subject to Deductible and Coinsurance.
Employee Assistance Program (Blue Cross)	Blue Cross will confidentially assess issues Eligible Individuals are facing, provide counseling to Eligible Individuals in an attempt to resolve those issues, and even refer them to others who can help them with those issues. A partial list of issues Blue Cross will address is contained in this booklet.
Mental Health Inpatient	$50.00 Copayment.
Mental Health Outpatient	$40.00 Copayment.
Chemical Dependency Inpatient	$50.00 Copayment.
Chemical Dependency Outpatient	$40.00 Copayment.
Maternity	Same benefits as for Sickness or accidental bodily Injury.
Birth Control	Voluntary vasectomies and other sterilization procedures. No coverage for prescription medication unless prescribed by a Physician to be Medically Necessary.
Dental Benefits	
Dental – impacted teeth removal and related charges only	No Copayment, but subject to Deductible and Coinsurance.

Other Expenses	
Infertility Treatment	Coverage provided for diagnostic work-ups and follow-ups. No coverage for hormone therapy, artificial insemination or any other direct attempt to induce or facilitate fertility or conception.
Reversal of voluntary sterilization	No Coverage.
Voluntary Abortion	Covered only if life of mother is threatened or pregnancy is the result of an assault.
Cosmetic or plastic surgery	No Coverage.
Physical exams for employment or insurance purposes	No Coverage.
Health services that are Experimental or Investigational	No Coverage.
Custodial or "Rest Cures"	No Coverage.
Surgery and care associated with morbid obesity	No Coverage, except as provided in the Covered Medical Expenses Section of this booklet and subject to the Plan's coverage rules.
Prescription Drug Benefits	
Outpatient Prescription Drugs & Diabetic Supplies (Prime Therapeutics) *Call Plan Administrator at 800-247-0401 for further information.*	***Please note**: Copayments for prescription drugs do not count towards reaching the annual maximum out-of-pocket Coinsurance expense limit for major medical benefits.* <u>Generic Drugs</u> - 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. <u>Brand Name Drugs</u> - 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.
Pharmacy Specialty Prescriptions *To obtain a current list of these prescriptions, call Plan Administrator at 800-247-0401*	Certain drugs will be subject to a Prior Authorization and some will also be subject to Quantity Level Limits. If your doctor recommends prescription quantities that exceed the limit your doctor will need to submit a prior authorization (PA) request that will include the medical reasons supporting that request to Prime Therapeutics. Your doctor can visit MyPrime.com to download the PA form.

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.

A. ELIGIBILITY DEFINITIONS

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.

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.

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.

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 as described in Paragraph B(1) below.

Premium Credit Account - An account established for all Bargaining Unit Employees to determine eligibility for benefits and if Self-Contributions are required to continue benefits. 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.

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

B. 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 choose to become initially eligible earlier, by paying out-of-pocket for coverage or borrowing Premium Credits from the Plan. This Section of the booklet explains these options.

Please note: Under either of these rules, any Self-Contributions must be timely paid or coverage under the Plan will terminate.

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 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 the Plan receives first go towards paying that negative balance off. After the Premium Credit Account balance is back to zero, the Plan must receive 135 more Premium Credits on behalf of that Bargaining Unit Employee in order 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. **Initial Eligibility: Options for New Employees**

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 who *has a negative Premium Credit Account balance on the date of hire, due to prior coverage under the Plan, may not choose between these options. That New Employee may become eligible only under the Initial Eligibility General Rule.*

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") or by borrowing any needed Premium Credits from the Plan (the "Premium Credit Loan" option). A New Employee may make that choice on the Eligibility Election Form provided during the job referral process at the Union hiring hall. That Form is also available from the Plan Administrator.

EXAMPLE

ASSUME JOHN WAS COVERED UNDER THIS PLAN AS BARGAINING UNIT EMPLOYEE THROUGH JULY 2009. HE LEFT THE TRADE FOR A FEW YEARS AND RETURNED TO WORK FOR A CONTRIBUTING EMPLOYER IN FEBRUARY 2012.

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 EITHER OPTION FOR NEW EMPLOYEES BUT MUST INSTEAD FOLLOW THE GENERAL RULE FOR INITIAL ELIGIBILITY.

a. Buy-in Option

Under this option, once the Plan has received eighty (80) Premium Credits on behalf of a New Employee, a 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 16th day of that Benefit Month.

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

b. Premium Credit Loan Option

Under this option, coverage begins on the first day of the first calendar month after the New Employee starts work as a Bargaining Unit Employee.

The Plan will credit the Premium Credit Account of each new Bargaining Unit Employee with the number of Premium Credits needed in each of the New Employee's first three (3) months of enrollment in the Plan (that is, the first three (3) calendar months after the month in which the New Employee started work as a Bargaining Unit Employee) to allow the New Employee to be eligible provided the New Employee remains actively employed as a Bargaining Unit Employee during each of those months. For each of those three (3) months, the Plan will credit the New Employee with the difference between the New Employee's Premium Credits actually reported to the Plan (as the result of employment as a Bargaining Unit Employee) for the Eligibility Month corresponding with that Benefit Month and the amount of Premium Credits required at that time to pay for one month of coverage. The combination of Premium Credits due to employment and Premium Credits provided by the Plan under the Premium Credit Loan Option will then be used to provide coverage for the new Bargaining Unit Employee as follows.

The Premium Credits in the New Employee's Premium Credit Account will be drawn upon by the Plan to provide coverage for the Benefit Month in which the Premium Credits are placed in the Premium Credit Account. After the first three (3) months of coverage, the New Employee may continue coverage through Premium Credits earned through employment as a Bargaining Unit Employee or by making a Self-Contribution if one is necessary.

Any Premium Credits which the New Employee earns which are in excess of the amount needed for coverage (currently that is, 135 per month) will first be used to "pay back" the Plan for the Premium Credits supplied to give the New Employee coverage in the first three (3) months of employment. The New Employee will be allowed twenty-four (24) months from the first month of eligibility to pay back these Premium Credits through a combination of excess Employer Contributions (currently that is, in excess of 135th per month) and Employee Self-Contributions. Any Premium Credits earned after the payback which are not immediately needed for coverage will be credited to the New Employee's Premium Credit Account (up to the Plan limit of twelve (12) months of Premium Credits).

If, at the end of the twenty-four (24) month period, the New Employee has not completed the payback, a Self-Contribution to complete the payback will be required.

The following example illustrates how this Premium Credit Loan Option operates.

EXAMPLE

ASSUME ANNE WORKED FIFTY (50) HOURS IN JUNE 2012, HER FIRST MONTH OF EMPLOYMENT AS A BARGAINING UNIT EMPLOYEE. ANNE SUBSEQUENTLY WORKED 125 HOURS IN JULY, 155 HOURS IN AUGUST, AND 190 HOURS IN SEPTEMBER. THE PLAN WILL CREDIT PREMIUM CREDITS TO ANNE'S PREMIUM CREDIT ACCOUNT AS FOLLOWS IN ORDER TO PROVIDE HER WITH COVERAGE BEGINNING JULY 1, 2012.

	June	July	August	September
Hrs. worked in month	50	125	155	190
Premium Credits applied to this Benefit Month (e.g. June hours apply to September Benefit Month)	0	0	0	50
Premium Credits needed for eligibility	0	135	135	135
Difference credited by Plan	0	(135)	(135)	(85)
Premium Account Balance	0	(135)	(270)	(355)

THIS EXAMPLE SHOWS THAT AFTER HER FIRST THREE (3) MONTHS OF COVERAGE, ANNE HAS A NEGATIVE BALANCE OF 355 PREMIUM CREDITS, TO BE PAID BACK TO THE PLAN OVER THE NEXT TWENTY-ONE (21) MONTHS.

IN OCTOBER, ANNE MUST MAKE SELF-CONTRIBUTIONS EQUAL TEN (10) PREMIUM CREDITS TO MAINTAIN ELIGIBILITY FOR THAT MONTH (BECAUSE THE 125 HOURS WORKED IN JULY ARE TEN (10) SHORT OF THE AMOUNT NECESSARY TO PROVIDE COVERAGE). HER PREMIUM ACCOUNT BALANCE WILL REMAIN AT (355) AT THE END OF THAT MONTH.

IN NOVEMBER, ANNE WILL HAVE COVERAGE BECAUSE THE 155 HOURS WORKED IN AUGUST ARE SUFFICIENT TO PROVIDE THAT COVERAGE. IN FACT, THIS IS TWENTY (20) MORE HOURS THAN ARE REQUIRED, SO THE TWENTY (20) EXCESS HOURS WILL BE APPLIED TO REDUCE HER NEGATIVE PREMIUM CREDIT ACCOUNT BALANCE TO (335).

IN DECEMBER, ANNE WILL HAVE COVERAGE BECAUSE THE 190 HOURS WORKED IN SEPTEMBER ARE SUFFICIENT TO PROVIDE THAT COVERAGE. IN FACT, THIS IS FIFTY-FIVE (55) MORE HOURS THAN ARE REQUIRED, SO HER NEGATIVE PREMIUM CREDIT ACCOUNT BALANCE WILL BE REDUCED BY THAT FIFTY-FIVE (55) HOURS TO (280).

3. **Eligibility Statement**

The Plan Administrator 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 Plan Administrator 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 reimbursed to the Employee by the Plan Administrator.

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.

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

The rules for continuing eligibility vary depending upon whether the Employee became initially eligible under: (1) the Initial Eligibility General Rule or the Buy-in Option, or (2) the Premium Credit Loan option. The rules that will apply in each case are described in detail below.

1. Continuing Eligibility for Those Becoming Eligible under the Initial Eligibility General Rule or the Buy-in Option

a. 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.

b. Self-Contributions

An Employee who does not have enough Premium Credits in his or her Premium Credit Account will have the right to make Self-Contributions for up to eighteen (18) months of health care coverage by paying the applicable premium on a timely basis to the Plan Administrator. 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 1.2 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 immediately.

Self-Contributions may be made for up to eighteen (18) months. 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. **Continuing Eligibility for Those Becoming Eligible Under the Premium Credit Loan Option**

a. Minimum Hours

Employees who become eligible under the Premium Credit Loan Option will be entitled to continue coverage under this set of rules for a period of up to twenty-four (24) months in total. Following the end of that twenty-four month (24) period, the Employee will continue eligibility under the rules described above in Paragraph 1, above.

To continue eligibility during the twenty-four (24) month period, the Employee must be credited in each month with Premium Credits attributable to Employer Contributions that are equal to at least one month's premium, or must make a timely Self-Contribution in the amount of the shortage. Excess Employer Contributions will be credited into the Employee's Premium Credit Account. These excess Contributions will first be used to satisfy any negative Premium Credit Account balance, and then will continue to accumulate in the Employee's Premium Credit Account until a maximum balance equal to twelve (12) months of premium is reached.

b. Self-Contributions

An Employee who terminates employment prior to curing a negative Premium Credit Account balance may continue coverage under the Plan by remitting self-payments under the rules for Self-Contributions described in the Paragraph 1, above.

c. Curing a Negative Premium Credit Account Balance

Employees who gained initial eligibility under the Premium Credit Loan Option will be allowed to maintain the resulting negative Premium Credit

Account balance for a period not to exceed twenty-four (24) months from the date of initial eligibility. At the end of that period, the Employee must remit a Self-Contribution in the amount of any remaining negative balance to the Plan Administrator. Any Employee who fails to make this payment in full by the 15th day of the 25th month following initial eligibility will lose coverage under the Plan effective as of the first day of that month and may regain eligibility only by satisfying the Initial Eligibility General Rule.

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

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. 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, 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 Employer Contributions and payroll deductions are received by the Plan.

3. Monthly Eligibility

Eligibility for L.E.A. employees is determined on a calendar month basis. Contributions are due on or before the 15th day of the month in which the L.E.A. employee is working under the L.E.A. Agreement (the "due date"). Contributions due in any month provide eligibility for that same calendar month.

4. Continuing Eligibility

L.E.A. employees will remain covered under this 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 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.

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. (See the Section of this booklet entitled "Continuation Coverage Under COBRA").

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 an amount from each L.E.A. employee's wages in an amount established in the L.E.A. Agreement. The Employer must send these amounts to the Plan Administrator. These payments must be received by the Plan Administrator's Office by the due date for the month in 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. 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").

E. 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 a Bargaining Unit Employee is eligible to continue coverage while Totally Disabled, he or she is subject to the following rules:

1. 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 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.

2. Proof of Total Disability must be sent to the Plan Administrator.

3. 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.

4. 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.

5. 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.

6. 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.

7. After the first 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; 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.

8. 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.

9. 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.

F. RECIPROCITY

Many times employees in the electrical industry may work in the 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.

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.

National Agreement

1. **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:

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

ii. 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. **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.

3. **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.

4. **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.

5. **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.

G. 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 complete an "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:

1. 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.

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

3. 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.

4. Return to coverage under the Plan <u>only if</u>:

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

      i. applies in writing to return to Plan coverage a) within thirty-one (31) days after losing the HSA/HDHP coverage, or b) 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

ii. the Dependent otherwise meets the eligibility requirements of the Plan; or,

b. The Eligible Employee dies and the Dependent then:

i. applies to return to Plan coverage a) within thirty-one (31) days after the Eligible Employee's death, or b) during the Plan's first open enrollment period (December 1 -31 of each Calendar Year for reinstatement effective January 1 of the next succeeding Calendar Year) after the Eligible Employee's death, and

ii. 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.

H. 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 in 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.

I. ELIGIBILITY REQUIREMENTS FOR OFFICE EMPLOYEES/EMPLOYERS (NON-BARGAINING UNIT EMPLOYEES)

1. Self-Contributions

Self-Contributions are required and must be received by the Plan Administrator during the month in which the coverage is to be effective. Failure to timely make the Self-Contribution will result in termination of coverage. It is not the responsibility of the Plan Administrator to notify Non-Bargaining Unit Employees of any Self-Contribution payment which is due. This self-pay period will end early if the Non-Bargaining Unit Employee becomes covered under another group health or group life plan.

Former Bargaining Unit Employees who become owners of Employers who are signatory to a Collective Bargaining Agreement providing for Contributions to the Plan, and who are also signatory to Participation Agreements covering Non-Bargaining Unit Employees, may apply positive Premium Credit Account balances against the premiums payable, to the Plan on their own behalves.

2. **Effective Date of Coverage for Non-Bargaining Unit Employees**

   Coverage will begin on the 1st day of the month following the date of hire as a Non-Bargaining Unit Employee if the Plan timely receives the required contributions.

3. **Employers Electing Non-Bargaining Coverage**

   Employers electing to cover their Non-Bargaining Unit Employees after January 1, 1980, are required to cover all full-time Employees in their office(s).

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 only by making Self-Contributions to the Plan through COBRA Continuation Coverage if legally entitled to do so. (See the Section of this booklet entitled "Continuation Coverage Under COBRA").

5. **Electrical Inspectors**

   Non-Bargaining Unit Employees who become inspectors in the electrical industry may continue their benefits under this Plan by making Self-Contributions. These individuals will have the same benefit levels as a regular Bargaining Unit Employee and may utilize their remaining Premium Credits.

J. 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:

1. The spouse is remarried.

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

3. 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).

4. 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.

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

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

7. 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.

K. MILITARY SERVICE

An Eligible Individual must inform the Plan Administrator in writing as soon as the Eligible Individual knows that he or she is entering military service.

1. **For Dependents Entering into Military Service**

   Coverage for a Dependent will cease on the date that Dependent enters military service.

2. **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).

3. **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.

4. **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:

a. 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.

b. 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.

c. 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 military leave.

d. 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.

5. **Termination of Military Continuation Coverage**

Military Continuation Coverage will cease on the earliest of:

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

b. 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

c. 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).

6. **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 Plan Administrator 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 frozen eligibility status restored.

If you exhausted your Premium Credits to pay for coverage while on military leave, 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 Plan Administrator 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 Plan Administrator if that has occurred.

7. **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.

L. FAMILY AND MEDICAL LEAVE

Under the Family and Medical Leave Act of 1993 (the "FMLA") and the National Defense Authorization Act of 2010, your Employer may be required to provide you (the Employee) with coverage under this Plan if you are away from work due to certain specified family and medical reasons. You will only be eligible for this protection if you are actively employed by a covered Employer that has fifty (50) or more employees for at least one (1) year. In addition, you must have worked at least 1,250 hours for that same Employer over the previous twelve (12) months at the time you wish to take FMLA Leave.

1. Reasons for Taking Leave

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

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

  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.

- 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;
- To care for your spouse, child, foster child, adopted child, stepchild or parent who has a serious health condition;
- For a serious health condition that makes it impossible for you to perform your job duties;
- 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
- 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.

You may be entitled to twenty-six (26) workweeks of coverage in a twelve (12) month period under the FMLA if your leave is due to any of the following reasons:

- 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. **Advanced Notice and Medical Certification**

The Plan may require you to provide advanced notice and medical certification before FMLA leave is granted. Leave may be denied if the following requirements are not satisfied:

- You must provide the Plan with thirty (30) days advance notice of your intent to take FMLA leave when it is foreseeable; and
- The Plan may require you to provide medical certification to support a request for leave due to a serious health condition; and
- The Plan may require second or third opinions (at the Plan's expense); and
- The Plan may require a fitness for duty report to return to work.

If you have any questions regarding leave under the FMLA, please contact the Plan Administrator.

M. EMERGENCY MEDICAL PROGRAM

Effective March 25, 2014, the emergency medical program is closed to new entrants. If you are Covered under the Emergency Medical Program on March 25, 2013, you may remain Covered until you reach the eighteen (18) consecutive month coverage limit or cease to make the required Self-Contributions, whichever comes first.

1. The Plan offers an Emergency Medical Program, which offers a lesser plan of benefits (as described in the Schedule of Benefits) at a monthly Self-Contribution amount that is lower than the Self Contribution amount that would be needed to maintain the regular Plan of Benefits. The Emergency Medical Program is available only to Bargaining Unit Employees who have previously satisfied the rules for initial eligibility under the Plan but who now:

    - Are out of work;
    - Are actively seeking work in the industry;

- Are "on the book"; and
- Do not have enough Premium Credits to pay for one month of coverage under the regular Plan of Benefits.

2. The Emergency Medical Program is only available by filing a completed election form with the Plan Administrator before the first date your coverage under the regular plan of benefits would end but for Self-Contributions (that is, while you are covered under the regular plan of benefits through Premium Credits).

3. Election forms received by the Plan Administrator after the applicable filing deadline indicated above will be denied as untimely. In other words, once that deadline passes, you will no longer be able to elect the Emergency Medical Program.

4. Your Premium Credit Account will be exhausted immediately when the Plan Administrator receives your timely application for the Emergency Medical Program. The first Self-Contribution amount due for coverage under the Emergency Medical Program will be reduced to reflect the value of any Premium Credits so exhausted. Later Self-Contribution amounts will reflect the full Self-Contribution amount required for coverage under the Emergency Medical Program.

5. The only way to return to coverage under the regular plan of benefits is by satisfying the Initial Eligibility General Rule.

6. You cannot remain covered under the Emergency Medical Program for more than eighteen (18) consecutive months. At the end of eighteen (18) consecutive months of coverage under the Emergency Medical Program, you and any other qualified beneficiary will have the right to elect Continuation Coverage under COBRA in order to continue coverage under the Emergency Medical Program.

7. Regardless of any provision of this Summary Plan Description that might say otherwise, a month during which you are 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.

N. RETIREES

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

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

ii. 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

iii. 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 are 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 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 RETIRES IN JANUARY 2012 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. **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:

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

      ii. 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;

iii. 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

iv. 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:

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

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

iii. The Board of Trustees approves the reinstatement.

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:

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

ii. 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).

iii. <u>Calculation of Months of Employment in the Industry</u>

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 later periods of employment in the industry, 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.

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

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

iv. Calculation of the Retiree Discount

Retirees with more than ten (10) full years will receive a discount of one percent (1%) of the cost of Retiree coverage for each credited year of employment in the industry.

EXAMPLE

JOE RETIRED IN SEPTEMBER 2012. 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 ALSO 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.

4. **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.

O. DIVORCE OR LEGAL SEPARATION

A divorced or legally separated Dependent spouse may make Self-Contributions for health benefits for up to thirty-six (36) months or, if earlier, until covered under another group health plan. See the Section of this booklet entitled "Continuation Coverage Under COBRA." A payment may or may not be required for the Dependent children.

P. DEPENDENT CHILDREN OF ELIGIBLE EMPLOYEES OF THIS PLAN WHO ARE LOSING THEIR ELIGIBLE DEPENDENT STATUS

Dependent children who no longer meet the definition of Dependent under the Plan may make Self-Contributions for health care benefits for up to thirty-six (36) months or, if earlier, until they are covered under another group health plan. See the Section of this booklet entitled "Continuation Coverage Under COBRA."

Q. CONTINUATION COVERAGE UNDER COBRA

The Weekly Income Disability Benefit and the Life Benefit are <u>NOT</u> provided under 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 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.

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"):

      i. A reduction in your hours of employment; or

      ii. 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 "Military Service" starting on page 26).

   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"):

      i. Your divorce or legal separation from your spouse;

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

      iii. Your death; or

      iv. 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. **Notification Responsibilities**

   - You, your spouse (or former spouse if your divorce or legal separation has already become final) and/or your Dependent child must notify the Plan Administrator if you get divorced or legally separated or if your Dependent child loses Dependent status. The Plan Administrator 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.

- It is your Employer's responsibility to notify the Plan Administrator 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 Plan Administrator any time any type of qualifying event occurs.

- You and/or your Dependents are also responsible for notifying the Plan Administrator 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.

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.

- 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)).

- 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).

- 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 Plan Administrator 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.

4. **COBRA Self-Contribution Procedures and Rules**

a. When the Plan Administrator 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 Plan Administrator 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.

d. If the completed Continuation Election form is not mailed to the Plan Administrator 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.

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.

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.

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.

7. **If You Have Questions** - Questions concerning the Plan or your Continuation Coverage rights should be addressed to the Plan Administrator. 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/ebsa.

R. 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:

1. 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.

2. 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.

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

An Eligible Employee who satisfies the eligibility requirements of Subsections B and C 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 Plan Administrator. 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.

The Eligible Employee and all of his or her Eligible Dependents understand that the following conditions apply 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:

1. 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.

2. 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.

3. 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.

4. 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.

5. 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.

6. The Eligible Employee and his or her Eligible Dependents may only return to coverage under the Plan <u>if</u>:

    a. 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; or

    b. 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.

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

T. 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 will result in suspension and/or loss of Plan coverage (See the Section entitled TERMINATION OF BENEFITS).

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 PLAN ADMINISTRATOR BEFORE THE PLAN CAN CONSIDER CLAIMS FOR BENEFITS.

A. 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.

B. DEPENDENTS

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

1. 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:

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

    b. 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.

2. 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:

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

    b. 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.

3. 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.

4. 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.

5. 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.

6. 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 Plan Administrator for each Dependent. Coverage will be effective on the date that the Plan Administrator approves the application.

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.

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.

AMBULATORY SURGICAL CENTER - A freestanding ambulatory surgical center, public or private, which meets the following criteria:

1. The facility provides organized medical staff of Physicians;

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

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

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

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

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

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

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.

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

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

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.

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.

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 and amendments to of such Collective Bargaining Agreement.

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.

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

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.

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.

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.

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.

DEPENDENT; ELIGIBLE DEPENDENT - An individual who is:

1. 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.

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

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

   b. 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

   c. 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.

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

   a. Your biological child.

   b. 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.

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

      i. Who was born to such spouse;

      ii. Who was legally adopted by such spouse;

      iii. Who has been placed for adoption with such spouse; or

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

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

e. 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.

4. 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.

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

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.

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.

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.

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.

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.

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.

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:

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

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

3. 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.

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.

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:

1. 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

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

3. 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

4. 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

5. 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

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

    a. 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;

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

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

    d. 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.

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.

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.

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:

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

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

3. 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

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

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:

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

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

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

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

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

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

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.

NON-ESSENTIAL HEALTH BENEFIT - Any Covered Expense that is not an Essential Health Benefit.

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

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.

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.

PLAN; PLAN OF BENEFITS - The Benefit Program provided by the South Central Minnesota Electrical Workers' Family Health Plan.

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.

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.

SCHEDULE OF BENEFITS; SCHEDULE - The Section of this Plan which outlines Plan benefits.

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.

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

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.

TOTAL DISABILITY; TOTALLY DISABLED -

1. 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.

2. 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 medical doctor chosen and paid for by the Plan.

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

TRUST AGREEMENT – The document called the "Trust Agreement, South Central Minnesota Electrical Workers Family Health Plan" which established the Trust Fund.

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.

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

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

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 BlueCard Program.

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.

A. 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.

B. EXCLUSIONS

No benefits are paid for:

- 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.

- Your death due to suicide or any self-inflicted Injury, unless the suicide or self-inflicted Injury results from a mental health or physical condition of the Eligible Employee.

- 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.

C. 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.

D. 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.

E. 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.

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.

A. ELIGIBILITY FOR BENEFITS

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

1. 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.

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

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

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

5. The Employee must satisfy the seven-day Waiting Period noted in the Schedule of Benefits.

6. 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.

B. 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.

C. 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.

D. 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, imagine that 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.

E. EXCLUSIONS AND LIMITATIONS

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

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

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

3. 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;

4. 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;

5. Alcoholism or drug addiction which is not being treated as an Inpatient in a Hospital or accredited treatment center or for any period of time beyond twenty eight (28) days; or

6. 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.

F. 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:

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

2. 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;

3. Any automobile 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;

4. Any plan, fund or other arrangement, by whatever name called, towards the cost of which the Employer will have contributed or with respect to which the Employer will have 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

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

G. 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.

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.

An annual maximum is set for the Essential Health Benefits payable on behalf of any Eligible Individual under this Plan as well as a lifetime maximum benefit for Non-Essential Health Benefits. Those "annual maximum" and "lifetime maximum" are described in this Section.

If you have questions about the benefits payable under these Sections, please contact the Plan Administrator.

A. ANNUAL MAXIMUM BENEFIT FOR ESSENTIAL HEALTH BENEFITS

The Plan will not pay more than $2,000,000 in benefits for Essential Health Benefits on behalf of any Eligible Individual during the Plan years that begin on July 1, 2011, July 1, 2012 and July 1, 2013.

For Plan Years beginning on or after July 1, 2014, the law currently does not permit the Plan to impose an annual maximum benefit on Essential Health Benefit. However, should the law change such that the Plan may continue to impose an annual maximum benefit on Essential Health Benefit for Plan Years beginning on or after July 1, 2014, the Plan may impose an annual maximum benefit on Essential Health Benefits.

B. LIFETIME MAXIMUM BENEFIT FOR NON-ESSENTIAL HEALTH BENEFITS

Each Eligible Individual is entitled to a lifetime maximum benefit of $2,000,000 for Non-Essential Health Benefits. This maximum includes all medical benefits paid in the past for Non-Essential Health Benefits under any previous medical plans of this Fund, plus all benefits paid for Non-Essential Health Benefits under the Plan as it currently provides for treatment of Injuries and Sickness during an Eligible Individual's lifetime. Once the lifetime maximum benefit for Non-Essential Health Benefits has been paid, no further medical expenses will be paid for that Eligible Individual from this Plan for Non-Essential Health Benefits.

C. CALENDAR YEAR DEDUCTIBLES

1. **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.

2. **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.

D. 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.

E. 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.

F. 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.

G. 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 see Paragraph (H) below for examples of how the Plan's Deductible, Copayment, Coinsurance and maximum out-of-pocket limits work.

H. 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
	$14,600
You pay 20% of the first $10,000 in Covered Charges	- $2,000
Plan pays the balance and	$12,600
Plan pays 80% of the first $10,000 in Covered Charges	-$8,000
	$4,600
Plan pays remaining Covered Charges at 100%	-$4,600
Total	$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 of (including one Hospital admission)	$25,000
You pay the Hospital admission Copayment of	- $50
You pay the individual Deductibles	- $700
	$24,250
You pay 20% of the first $20,000 in Covered Charges	- $4,000
Plan pays the balance and	$20,250
Plan pays 80% of the first $20,000 in Covered Charges	-$16,000
	$250
Plan pays remaining Covered Charges at 100%	-$250
Total	$0

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

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 services, supplies, and types of treatment:

A. HOSPITAL SERVICES AND SUPPLIES

1. 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.

2. 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.

B. TRANSPORTATION SERVICES

1. Emergency local transportation by professional ambulance service other than air ambulance, limited to the first trip to and from a Hospital for any one Sickness and for all Injuries sustained in any one accident; 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:

    a. The transportation must be by regularly scheduled commercial airline or railroad or by professional air ambulance;

    b. 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;

    c. 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

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

C. 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.

D. 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.

E. RECONSTRUCTIVE SURGERY

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

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

F. 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 (a) an immediate relative with breast cancer, or (b) 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.

G. 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). The Plan may change these additional conditions, limitations, and exclusions from time to time. 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.

H. DIAGNOSTIC X-RAYS AND LABORATORY EXAMINATION BENEFIT

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

I. MATERNITY BENEFIT EXPENSES

This benefit includes expenses for delivery in a Hospital and for Medically Necessary 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.

J. PREVENTIVE CARE AND IMMUNIZATIONS

1. Covered Preventive Care Services

The Plan will cover 100% of the reasonable and customary charge for the following preventive care services 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 only applicable to Eligible Individuals forty (40) years of age and older and one procedure is covered every five (5) years, unless there is a Clinical History of colon disease.

c. **Services for Women.** Mammography and Pap smear.

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 Clinical History of prostate disease.

e. **Services for Newborns**. In addition to other benefits available to Dependent children, a newborn Dependent child will be entitled to (a) routine nursery care and routine well baby care while Hospital confined due to birth and (b) 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).

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 without application of the deductible.

a. **Preventive Care Services for Adults:**

i. Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
ii. Aspirin use to prevent cardiovascular disease for men and women of certain ages
iii. Blood Pressure screening for all adults
iv. Cholesterol screening for adults of certain ages or at higher risk
v. Colorectal Cancer screening for adults over 50
vi. Depression screening for adults
vii. Diabetes (Type 2) screening for adults with high blood pressure
viii. Diet counseling for adults at higher risk for chronic disease
ix. HIV screening for everyone ages 15 to 65, and other ages at increased risk
x. 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,
xi. Obesity screening and counseling for all adults
xii. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
xiii. Syphilis screening for all adults at higher risk
xiv. Tobacco Use screening for all adults and cessation interventions for tobacco users

b. **Preventive Care Services for Women:**

i. Anemia screening on a routine basis for pregnant women
ii. Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer
iii. Breast Cancer Mammography screenings every 1 to 2 years for women over 40
iv. Breast Cancer Chemoprevention counseling for women at higher risk
v. Breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women
vi. Cervical Cancer screening for women at higher risk
vii. Chlamydia Infection screening for younger women and other women at higher risk

viii. 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
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

ix. Domestic and interpersonal violence screening and counseling for all women
x. Folic Acid supplements for women who may become pregnant
xi. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
xii. Gonorrhea screening for all women at higher risk
xiii. Hepatitis B screening for pregnant women at their first prenatal visit
xiv. HIV screening and counseling for at higher risk women
xv. Human Papillomavirus (HPV) DNA Test every 3 years for women with normal cytology results who are 30 or older
xvi. Osteoporosis screening for women over age 60 depending on risk factors
xvii. Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
xviii. Sexually Transmitted Infections counseling for sexually active women
xix. Syphilis screening for all pregnant women or other women at increased risk
xx. Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users
xxi. Urinary tract or other infection screening for pregnant women
xxii. Well-woman visits to get recommended services for women under 65

c. **Preventive Care Services for Children:**

i. Alcohol and Drug Use assessments for adolescents
ii. Autism screening for children at 18 and 24 months
iii. 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.
iv. 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.
v. Cervical Dysplasia screening for sexually active females
vi. Depression screening for adolescents
vii. Developmental screening for children under age 3
viii. 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.
ix. Fluoride Chemoprevention supplements for children without fluoride in their water source
x. Gonorrhea preventive medication for the eyes of all newborns
xi. Hearing screening for all newborns
xii. 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.
xiii. Hematocrit or Hemoglobin screening for children
xiv. Hemoglobinopathies or sickle cell screening for newborns
xv. HIV screening for adolescents at higher risk
xvi. Hypothyroidism screening for newborns
xvii. Immunization and vaccines for children from birth to age 18 - doses, recommended ages, and recommended populations vary:

Diphtheria-Tetanus-Pertussis, Haemophilus influenzae type b, Hepatitis A, Hepatitis B, Human Papillomavirus, Inactivated Poliovirus, Influenza (Flu Shot), Measles-Mumps-Rubella, Meningococcal, Pneumococcal, Rotavirus, Varicella

xviii. Iron supplements for children ages 6 to 12 months at risk for anemia
xix. Lead screening for children at risk of exposure
xx. 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.
xxi. Obesity screening and counseling
xxii. Oral Health risk assessment for young children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.
xxiii. Phenylketonuria (PKU) screening for this genetic disorder in newborns
xxiv. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk
xxv. 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.
xxvi. 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, co-payment, and co-insurance provisions.

K. HEALTH CLUB DISCOUNT PROGRAM

An Employee or Retiree and one of his or her Dependents who is age eighteen (18) or older may participate in the Fitness Discount Program by enrolling at www.bluelinktpamn.com. To begin, click on the “Members” tab at the top of the screen. Then click on the “Learn More” tab under the “Health & Wellness Services” Next, scroll down the page to additional services and click on “Fitness Discounts”. Finally, click on “Find a Fitness Center Near You” at the bottom of the page and enter your search criteria. Once you locate a Fitness Center, you can either enroll online (if this option is available at the location you select) or visit the location and enroll onsite. Enrolled individuals will receive a $20.00 credit on his or her health club membership for each month during which he or she uses the designated fitness center at least twelve (12) times. The maximum aggregate credit one family may receive for any given month is $40. The enrolled individual must follow all rules of the program to be entitled to the discount.

L. OTHER COVERED EXPENSES

1. 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.

2. Drugs and medicines which require the written prescription of a Physician 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.

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

4. The use of radium and radioactive isotopes.

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

6. Anesthesia.

7. X-ray and laboratory examinations.

8. Professional nursing services by registered graduate nurses or licensed practical nurses, other than a Close Relative, and provided the services are Medically Necessary.

9. Physiotherapy excluding physiotherapy treatment by a Close Relative.

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

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

12. 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 to exceed the purchase price.

13. Surgical dressings.

14. 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.

15. 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.

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

17. 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.

18. Eye refractions, but only to the extent they are Medically Necessary for the diagnosis or treatment of Sickness or Injury.

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

20. One course of diabetes management education every two (2) years, or more frequently if justified by a documented significant change in the Eligible Individual's health status.

M. HOSPICE CARE

Subject to the "Provisions Governing Hospice Care."

N. HOME NURSING CARE

Subject to the "Provisions Governing Home Nursing Care."

O. SKILLED NURSING FACILITY CARE

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

P. PREFERRED PROVIDER PHARMACY PRESCRIPTION DRUG BENEFITS

Subject to the "Provisions Governing Prescription Drug Benefits."

Q. GENETIC TESTING

Genetic Information Nondiscrimination Act. 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:

1. Coverage is not otherwise excluded by the Plan.

2. Either:

   a. 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

   b. 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

c. 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.

3. 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.

4. 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.

5. 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.

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

R. REPLACEMENT OF ORGANS AND TISSUE BENEFIT

The Plan covers expenses for services, supplies, drugs, and related aftercare for approved human organ and tissue transplant, bone marrow transplant and stem cell support procedures as provided below.

1. Approved Procedures Not Subject to Special Requirements

Charges incurred for kidney (except kidney transplants from a live donor), cornea, and skin transplants are covered if they (1) are Medically Necessary (which requires, among other things, that the transplants are not Experimental or Investigative), and (2) are payable under all other provisions of this Plan document. Kidney transplants (other than kidneys from a live donor), corneal transplants and skin transplants are not subject to the Special Requirements for Transplant Procedures discussed below.

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

2. Procedures Subject to Special Requirements

The following transplant procedures are covered if they are: (i) Medically Necessary (which requires, among other things, that the transplants 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 listed in Subsection 3 below:

a. Kidney transplants (from a live donor);

b. Heart transplants;

c. Heart-lung transplants;

d. Liver transplants;

e. Lung transplants (single or double);

f. Pancreas transplant for:

i. 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

ii. a medically uncontrollable, labile diabetic with one or more secondary complications, but whose kidneys are not seriously impaired;

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

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

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

The Plan's Board of Trustees reserves the right to change (but is not required to change) the above list of transplant procedures which are approved for coverage.

3. **Special Requirements for Transplant Procedures**

a. Authorization from the Plan for a transplant procedure must be obtained from the Plan Administrator 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 that a request for authorization is made, the Plan Administrator will identify the Plan's case manager assigned to the transplant procedure.

c. Coverage is limited to two (2) transplant procedures for the same condition per Eligible Individual per lifetime.

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 Income Disability Benefits will not be payable to an organ or tissue donor unless the donor is an Eligible Employee otherwise eligible for the benefits under this Plan.

e. If the transplant donor is covered under this Plan, but the recipient is not, medical expenses of the donor will be considered for payment under the Plan only to the extent they are not payable under any other plan of

benefits. Benefits for expenses incurred by the recipient will not be payable.

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 which:

i. Identifies the proposed recipient's medical condition for which the transplant procedure is requested;

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

iii. Certifies 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 will be required for all proposed transplant procedures.

4. **Excluded Expenses** - Expenses related to the following are not Covered Expenses (i.e., are excluded):

a. Services or supplies not reimbursed 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 such transplant.

c. Physician, Hospital and other covered health care provider services or supplies for which no charge is made or, further, for which no charge would routinely be made in the absence of insurance or health plan coverage.

d. Transplantation or implantation of a non-human organ or tissue.

e. Implant of an artificial or mechanical heart or part thereof.

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

g. 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 which have not been approved for general sale and distribution by the U.S. Food & Drug Administration.

h. Air ambulance transportation, except with respect to the transportation of the organ to the location of the surgery when such 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 such waiver apply to organs obtained outside of the United States or Canada.

i. Living donor transplants of the liver, lung or any other organ, such as selective islet cell transplants of the pancreas.

j. Re-transplant of organ or bone marrow during the 365-day period following the transplant procedure.

S. 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 Plan Administrator for more information.

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

- Have not already been detected by the Plan Administrator or reported by the provider; and
- Involve charges which are allowable and covered by the Plan.

To receive the self-audit award, the Participant must:

- Notify the Plan Administrator of the error before it is detected by the Plan or the health care provider;
- Contact the provider to verify the error and obtain a corrected bill; and
- Have copies of the correct billing sent to the Plan Administrator for verification, claims adjustment and calculation of the Self-Audit credit.

T. 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 paragraph, 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.

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. Any benefits paid for Hospice care also apply to the Major Medical Expense Lifetime Maximum Benefit.

A. SPECIAL DEFINITIONS

1. **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.

2. **Terminal, Terminally-Ill** - An individual's medical prognosis indicates a life expectancy of six (6) months or less.

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

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

5. **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.

B. 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.

C. 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, the individual 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.

D. 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.

E. 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:

1. Nursing care by an RN or LPN;

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

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

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

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

3. Psychological and dietary counseling;

4. Physical and occupational therapy and speech language pathology;

5. Non-prescription drugs used for Palliative Care;

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

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

F. EXCLUSIONS AND LIMITATIONS OF THE HOSPICE CARE PROGRAM

Charges for the following services and supplies are not covered under the Hospice Care Program:

1. Any services or supplies not provided as “core services” by the Hospice providing the Hospice care;

2. Bereavement counseling (counseling services provided to a Terminal individual’s family after death);

3. Administrative services;

4. Homemaker or caretaker services, which are services not solely related to care of the covered Eligible Individual, including:

   a. Sitter or companion services for either the family member who is ill or other members of the family;

   b. Housecleaning;

   c. Maintenance of the house; and

5. Transportation, except in emergency situations;

6. Long-term Inpatient care (These charges are considered for payment under the regular Covered Medical Expenses provisions of the Major Medical Expense Benefit);

7. 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

8. 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).

PROVISIONS GOVERNING HOME NURSING CARE

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

A. 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:

1. The home nursing care must be certified as follows:

   a. 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

   b. 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.

2. 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:

   a. It is primarily engaged in providing skilled nursing services and other therapeutic services in the homes of its patients;

   b. 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;

   c. It provides for full-time supervision of its services by a Physician or a registered graduate nurse;

   d. It maintains a complete medical record on each of its patients;

   e. 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;

   f. It has a full-time administrator; and

   g. it is eligible to participate in Medicare.

B. **COVERED SERVICES AND SUPPLIES** - Covered Expenses include charges incurred for the following services and supplies provided by or through a Home Health Agency:

1. Part-time or intermittent care provided by home health aides under the supervision of a registered graduate nurse;

2. 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

3. Medical supplies (other than drugs and biologicals) provided by the Home Health Agency.

C. **EXCLUSION**: No payment will be made for child care or housekeeping services.

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.

C. REQUIREMENTS FOR AN APPROVED SKILLED NURSING CONFINEMENT

1. A Physician must certify that the confinement and nursing care are Medically Necessary for the Eligible Individual's recuperation from an Injury or Sickness;

2. The confinement must be preceded by at least three (3) consecutive days of a Hospital confinement for which Plan benefits are payable;

3. The confinement must start within three (3) days after discharge from the Hospital confinement for which Plan benefits are payable;

4. The confinement must be for the same condition which required the previous Hospital confinement; and

5. 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:

   a. 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;

   b. 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;

   c. It provides 24-hour-a-day nursing services by licensed nurses under the supervision of an registered graduate nurse and it has a registered graduate nurse on duty at least eight (8) hours a day;

d. 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;

e. It maintains daily medical records on all patients, and it provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;

f. It has an effective utilization review plan;

g. It has a transfer agreement with one or more Hospitals;

h. It is eligible to participate under Medicare; and

i. 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.

PROVISIONS GOVERNING PRESCRIPTION DRUG BENEFITS

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

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 Prime Therapeutics to provide prescription drugs at discounted prices. Under this agreement, Prime Therapeutics 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 Plan Administrator regarding the operation of this program.

A. 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:

1. Present the identification card to the pharmacist with the prescription;

2. Verify and sign the claim voucher prepared by the pharmacist; and

3. 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:

Prime Therapeutics
Mail Route BCBSMN
P.O. Box 14501
Lexington, KY 40512-4501

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.

B. PAYMENT OF BENEFITS (MAIL ORDER PROGRAM)

Eligible Individuals may also obtain discounted maintenance prescription drugs through the mail order program or the 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 Plan Administrator 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 Plan Administrator contains the order form for you to use to order prescription drugs through the mail. The Plan Administrator 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 www.MyPrime.com. For subsequent fills of the same prescription, you may call 1-877-357-7463 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 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.

C. 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.

D. EXCLUSIONS

Benefits are not payable under this Section for:

1. Drugs which are lawfully obtainable without a prescription, except insulin and insulin syringes;

2. Therapeutic devices or appliances, including support garments and other non-medical substances regardless of their intended use;

3. Administration of prescription legend drugs or injectable insulin;

4. Drugs labeled: “Caution - limited by federal law for investigational use,” or Experimental drugs, even though a charge is made to the individual;

5. Patent medicines or drugs, or any other medicine not legally dispensed by a registered pharmacist according to the written prescription of a Physician;

6. Refilling of a prescription in excess of the number specified by a Physician or Dentist;

7. 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;

8. Any prescription drug expense if you are enrolled in Medicare Part D;

9. Diaphragms, contraceptive jellies and ointments, foams or devices;

10. Vitamins, cosmetics and dietary aids, except where classified as “prescription legend drugs”; and

11. Any expenses whatsoever under the Prescription Drug Benefit where payment will exceed a benefit limit or maximum set forth in the Schedule of Benefits.

MENTAL HEALTH AND CHEMICAL DEPENDENCY BENEFIT

A. YOUR EMPLOYEE ASSISTANCE PROGRAM PROVIDED THROUGH BLUE CROSS BLUE SHIELD OF MINNESOTA

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 Blue Cross Blue Shield of Minnesota 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 Blue Cross counselor can help you with:

- Family and marriage problems;
- Alcohol or controlled substance dependency;
- Financial concerns;
- Emotional problems;
- Legal referrals;
- Medical concerns; and
- 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.

1. How to Use Your Employee Assistance Program

If you need help with a problem, just dial the confidential hotline at **(651) 662-0900 or 1-800-432-5155**. Some problems can be resolved with a counselor in just a few minutes over the phone. Or, you may choose to schedule a meeting with a counselor at any of Blue Cross's convenient locations.

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. Your 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 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.

2. **Coinsurance.** Please see the Schedule of Benefits of information about Coinsurance.

B. MENTAL AND NERVOUS DISORDER BENEFIT

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:

i. 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;

ii. The facility must have a full-time psychologist or psychiatrist on staff; and

iii. The treatment must be provided by licensed counselors.

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:

302.5 Trans-sexualism
Excludes transvestism (302.3)
302.50 with unspecified sexual history
302.51 with asexual history
302.52 with homosexual history
302.53 with heterosexual history

302.6 Disorders of psychosexual identity
Feminism in boys
Gender identity disorder of childhood
Excludes gender identity disorder in adult (302.85)
homosexuality (302.0)
trans-sexualism (302.50-302.53)
transvestism (302.3)

302.7 Psychosexual dysfunction
Excludes impotence of organic origin (607.84)
normal transient symptoms from ruptured hymen
transient or occasional failures of erection due to fatigue, anxiety, alcohol, or drugs
302.70 Psychosexual dysfunction, unspecified
302.71 with inhibited sexual desire
302.72 with inhibited sexual excitement
Frigidity
Impotence
302.73 with inhibited female orgasm
302.74 with inhibited male orgasm
302.75 with premature ejaculation
302.76 with functional dyspareunia
Dyspareunia, psychogenic
302.79 with other specified psychosexual dysfunctions

302.8 Other specified psychosexual disorders
302.81 Fetishism
302.82 Voyeurism
302.83 Sexual masochism

302.84 Sexual sadism
302.85 Gender identity disorder of adolescent or adult life

C. 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.

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:

i. A Hospital which meets the Plan’s definition of Hospital; or

ii. 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

iii. 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:

i. Detoxification Treatment - Medical care for detoxification will be covered only if followed by an approved long-term, after-care program; and

ii. Rehabilitative Treatment - Consultation and group therapy for rehabilitative treatment.

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.

PREMIUM CREDIT ACCOUNTS REIMBURSEMENT PROGRAM

Due to the Plan's deductible, coinsurance, and co-pay 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. If your Premium Credit Account has more Premium Credits than the amount needed to pay for three months of coverage, you can use the excess Premium Credits to be reimbursed for any portion of Covered Medical Expenses, dental expenses, or vision expenses or co-premiums on your Spouse's Health Plan that you or your Dependents must pay. To use Premium Credits to pay co-premiums on your Spouse's Health Plan, you must first submit documentation to the Plan Administrator demonstrating to the Plan Administrator's satisfaction that the Plan is compliant with ACA provisions. Please contact your Plan Administrator for additional information.

You can use the equivalent of $2,500 in Premium Credits each calendar year for reimbursement under the Premium Credit Accounts Reimbursement Program. This is the maximum aggregate reimbursement per family, per calendar year. No reimbursement may draw your Premium Credit Account down below the amount needed to pay for three months of coverage.

You must submit a claim for reimbursement under the Premium Credit Accounts Reimbursement Program no later than March 31st 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 Plan Administrator will process reimbursements just once per calendar month. To be reimbursed, you must submit a completed reimbursement claim form along with documentation of the expense. Contact the Plan Administrator to request reimbursement forms.

The Plan Administrator 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 Plan Administrator for the current processing fee. All the claims you submit them 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.

RETIREE BENEFITS

When you Retire, you can continue your coverage for yourself and your Dependents in one of two (2) ways:

1. 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.

2. Retiree Benefits are available for you and your Dependents as long as you make the correct Self-Contributions on time.

A. 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.

B. ELIGIBILITY FOR RETIREE BENEFITS

The eligibility rules for Retirees are found in the Section of this booklet entitled "Eligibility".

C. PAYMENT OF SELF-CONTRIBUTIONS FOR RETIREE BENEFITS

To ensure maximum Retiree benefits, you should follow these rules for the payment of Self-Contributions:

1. 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.

2. The amount of the monthly Self-Contribution is determined by the Trustees and may be changed at any time.

3. You must mail your Self-Contributions to the Plan Administrator. Each payment must be received no later than the 1st day of the benefit month for which you are paying in order to be accepted by the Plan Administrator. For example, to be covered for benefits during the March benefit month, your Self-Contribution must be received no later than March 1st.

4. 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.

5. 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.

6. 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.

D. 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:

1. The amount of benefit available from this Plan is determined by the Schedule of Benefits;

2. The amount that Medicare pays is subtracted from the amount of benefit payable by this Plan; and

3. If the amount Medicare pays is larger than the amount of benefit available, no payment is made by the Plan.

E. SURVIVING DEPENDENTS OF RETIREES

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.

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.

3. **Continuation Coverage Under COBRA Benefits** - If your death occurs while you are making Continuation Coverage under 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.

F. TERMINATION OF BENEFIT COVERAGE FOR RETIREES AND THEIR DEPENDENTS

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; or

   d. The date of your death.

   e. The occurrence of any event delineated in Subsection A, entitled; Bargaining Employees, Non-Bargaining Employees and Retirees of the "TERMINATION OF BENEFITS" Section.

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 meeting this Plan's definition of a Dependent unless the Dependent is entitled to elect, and does elect, to make Self-Contributions for Continuation Coverage Under COBRA;

f. In the event of your death while you are making Self-Contributions for Continuation Coverage, at the end 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 the end 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:

i. At the end 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;

ii. If your surviving spouse is making Self-Contributions to continue Retiree Benefits for himself/herself and any Dependent children:

I. If a correct and on-time Self-Contribution fails to be made by or on behalf of the Dependent, 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;

II. The date the child fails to meet the definition of a Dependent child;

III. With respect to the surviving spouse, the date on which he or she remarries or dies, whichever occurs first; or

IV. With respect to a Dependent child in the event of the surviving spouse's death, at the end 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;

iii. 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:

I. 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;

II. The date the child fails to meet the definition of a Dependent child; or

III. At the end 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.

i. The occurrence of any event delineated in Subsection A, entitled; Bargaining Employees, Non-Bargaining Employees and Retirees of the "TERMINATION OF BENEFITS" Section.

G. 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:

1. 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

2. 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, you must:

1. Notify the Plan Administrator in writing of your election to temporarily opt out of Retiree Benefits coverage within thirty (30) days of the date of your retirement and, at that time, provide the Plan Administrator with sufficient documentation to establish that you are covered under your spouse's health plan or under government-sponsored health coverage.

2. Notify the Plan Administrator 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.

3. Your Retiree Benefits coverage under this Plan will then begin on the first day of the month following the month in which the Plan Administrator receives your written election to opt back into coverage under this Plan.

4. 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.

5. If you qualify to opt back into coverage, all of the requirements concerning Retiree Benefits coverage will apply, such as Self-Contribution requirements.

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 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.

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. Exception: This exclusion does not apply to the extraction of partially or completely unerupted 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.

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.

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, including 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, 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 any operation or treatment in connection with sex transformations or any type of sexual dysfunction, including any complications arising there from.

ZZ. For birth control medications unless they are prescribed by a Physician for therapeutic treatment of a specific Sickness, or for contraceptive devices or any other method of contraception other than covered surgical sterilization.

AAA. For charges incurred by Dependent children for vasectomies or other sterilization procedures unless recommended by a Physician for therapeutic purposes of the patient.

BBB. For the reversal of, or attempts to reverse, a previous elective sterilization.

CCC. 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.

DDD. For charges incurred in connection with any pregnancy for which benefits are payable under any prior plan of group insurance.

EEE. For charges incurred in connection with voluntary abortion. Exception: 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.

FFF. 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.

GGG. 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.

HHH. 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.

III. 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.

JJJ. 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, or war-like activity by any individual, government, military, sovereign group, terrorist or other organization.

KKK. For charges resulting from any intentionally self-inflicted Injury. Exceptions: 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.

LLL. For charges for an Injury or Sickness resulting from engaging in an illegal act. For purposes of this Paragraph (LLL), "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). Exception: 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.

MMM. 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.

NNN. For charges incurred as a result of any automobile, motorcycle, watercraft or other recreational vehicle or motor vehicle (collectively "Vehicle") accident:

1. Where the Eligible Individual fails to 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 (OOO) through (UUU) will apply.

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.

OOO. 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.

PPP. 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.

QQQ. 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.

RRR. 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.

SSS. 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.

TTT. 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.

UUU. 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.

VVV. 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.

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.

- The Trustees of the Plan have the sole authority to interpret this document, and any other documents concerning the Plan.
- 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.
- Your claims for benefits must be filed within certain time limits described in these Sections.
- 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.

A. RULES GOVERNING PAYMENT OF BENEFITS

The following rules affect the payment of benefits from this Plan:

1. 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.

2. 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 Plan Administrator 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.

3. You or your spouse, in most cases, can assign benefits to Physicians, ambulance services, laboratories, etc. This means that you sign a form that tells the Plan Administrator 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 Blue Cross Blue Shield of Minnesota 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 Blue Cross Blue Shield of Minnesota Network Service Area.

4. "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.

5. 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.

6. Payments are made for treatment of Injuries and Sicknesses only if they are non-occupational (not related to work).

7. 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.

8. Charges are considered for payment only if they are incurred while the individual is Covered Under The Plan.

9. 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.

10. Benefits will be payable only for expenses which are actually incurred.

11. The self-funded (self-insured) benefits payable under this Plan are limited to the assets available for those purposes regardless of accumulated eligibility.

12. Expenses incurred by female Eligible Individuals for a maternity or pregnancy-related condition are treated the same as expenses incurred for a Sickness.

13. 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.

14. Your life benefit will be paid to your Beneficiary.

15. 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.

16. 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.

17. 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.

18. 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.

19. Providers will be paid as follows:

    a. For benefits charges incurred with participating 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;

    b. For benefits charges incurred with non-participating providers within the geographic area of the Blue Cross Blue Shield Minnesota AWARE Network, the Plan will pay the Reasonable and Customary Charge, or if applicable, a separately negotiated amount to 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;

    c. Benefits charges incurred with non-participating providers outside the geographic area of the Blue Cross Blue Shield Minnesota AWARE Network will come through Blue Cross' Blue Card program. The Plan will pay the Reasonable and Customary Charge as provided by the Blue Card Host Plan in the Blue Card system 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.

B. 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 a participant or beneficiary, 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 participant or beneficiary.

C. 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).

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. 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.

- Group, Blanket or Franchise Insurance;
- Blue Cross and Blue Shield plans on a group basis;
- Group practice plans;
- Coverage under Government programs, or required or provided by statute (other than a welfare plan);
- Group pre-payment plans;
- Coverage required or provided by law;
- Group auto insurance; and

- 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 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 Employee 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.

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.

3. **Order of Benefit Payments**

The order of benefit payments is determined as follows:

a. Both Employees of 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:

i. *Parents Not Legally Separated or Divorced*. With respect to claims filed on behalf of a Dependent child of parents are not legally separated or divorced:

I. *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;

II. *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

III. *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.

ii. *Divorced or Legally Separated*. With respect to claims filed on behalf of a Dependent child of parents are legally separated or divorced:

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 Employees of 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.

4. **Right to Release and Receive Information**

As permitted by law, the Plan Administrator may, without the Employee's consent:

a. Obtain information from all Plans which might be involved.

b. Release to the Other Plans any information in the Plan Administrator'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).

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.

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.

D. COORDINATION OF BENEFITS WITH MEDICARE

1. **For Retirees Eligible for Medicare** - If you are a Retiree who is eligible for Medicare, This Plan will coordinate its benefits with Medicare 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 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.

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 Plan Administrator 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:

      i. 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.

      ii. 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.

      iii. 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:

         I. 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.

         II. 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.

E. COORDINATION OF BENEFITS WITH AUTOMOBILE, MOTORCYCLE, WATERCRAFT, OTHER RECREATIONAL VEHICLE AND MOTOR 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:

1. Benefits payable under the 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.

2. For any expenses arising from the maintenance or use of an automobile, motorcycle, watercraft, other recreational and motor 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.

3. 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.

4. An individual injured in an automobile, motorcycle, watercraft, other recreational and motor 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.

F. 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, 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.

G. 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.

H. HOW TO APPLY FOR BENEFITS

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!

2. Incomplete Claims

If you send a claim to the Plan Administrator 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 Plan Administrator. Approval or denial of a claim will be made within time frames listed below.

3. Claim Filing and Processing Procedures

To help the Plan Administrator 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 <u>not</u> a member of that Preferred Provider Network, you must complete and submit claim forms as described below.

i. Obtain the proper claim form.

I. If possible, call the Plan Administrator a few days before treatment is started or you are hospitalized to request a claim form, or

II. 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:

Employee's name; and

Employee's Social Security number.

ii. 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.

iii. 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.

iv. Attach all bills or receipts relating to the health service provided.

v. Make sure each bill clearly identifies the service (or supply), the fee, the patient's name and the date of service.

vi. 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.

vii. 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:

i. 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 March 31st of the Calendar Year immediately following the Calendar Year in which the Covered Medical Expense was incurred.

ii. Contact the Plan Administrator to obtain a Reimbursement Claim Form or to obtain instructions for filing your claim with the Plan.

iii. 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.

iv. Send the Reimbursement Claim Form and EOB(s) or itemized bill(s) to the Plan Administrator at:

Alan Sturm & Associates, Inc.
8120 Penn Avenue South, Suite 500
Bloomington, MN 55431

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.

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.

5. **Time of Payment of Claims.** After the Plan Administrator receives written proof of loss, 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 Plan Administrator receives written proof.

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.

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 Plan Administrator, under "Facility of Payment" (as described below.) The Plan Administrator can pay all or a part of any benefits provided for health care services to the provider if the Employee so directs in writing.

8. **Facility of Payment - For All Benefits Other Than Life Benefits.** If benefits are payable to the Employee's estate, the Plan Administrator can pay up to $1,000.00 of benefits to someone related to the Employee by blood or marriage whom the Plan Administrator 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 Administrator 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.

9. **Forward Completed Claim Form and All Related Bills to the Plan Administrator:**

Alan Sturm & Associates, Inc.
8120 Penn Avenue South, Suite 500
Bloomington, MN 55431

I. INITIAL CLAIM REVIEW PROCEDURES

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.

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.

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.

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 notifies you of the reason for the extension (and the expected decision date) within forty-five (45) days after receiving the claim. The Plan may extend this extended deadline up to an additional thirty (30) days if the additional extension is due to matters beyond the Plan's control as long as the Plan notifies you of the reason for the extension (and the expected decision date) within seventy-five (75) days after receiving the claim. In either case, the 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.

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 and 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.

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 provision(s) 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; and

g. If the claim is an urgent care claim, describe the expedited review process applicable to urgent care claims (which is also discussed above).

J. APPOINTING AN AUTHORIZED REPRESENTATIVE TO ACT ON YOUR BEHALF

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 Plan Administrator at 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.

K. 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 Plan Administrator at the following address:

South Central Minnesota Electrical Workers' Family Health Plan
c/o Alan Sturm & Associates, Inc.
8120 Penn Avenue South, Suite 500
Bloomington, MN 55431

1. Deadline for Filing Claim Appeals

Your claim appeal must be filed in writing and must be delivered to the Plan Administrator at the Fund Office within 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.

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.

3. **Applicable Time Frames for Deciding Claim Appeals**

The applicable time frame 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 (Post-Service and Disabilities 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 thirty (30) days of the next regularly scheduled meeting, the Board of Trustees will review your appeal at the Board's second regularly scheduled meeting following the Plan Administrator's receipt of your claim appeal. 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.

Once your appeal is reviewed, you will be notified of the appeal decision by the Plan within five (5) days.

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.

L. 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:

1. The individual on whose behalf you filed the claim was not eligible for benefits on the date the expenses were incurred.

2. You did not file the claim within the Plan time limits.

3. The expenses that were denied are not Covered Expenses or the expenses for which you filed the claim were not actually incurred.

4. 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.

5. 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.

6. 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.

7. Another plan was primarily responsible for paying benefits for the expenses (see the Section on Coordination of Benefits).

8. The Trustees amended the Plan eligibility rules or decreased Plan benefits.

9. 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.

10. 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.

11. 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.

M. 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:

1. The claim would have been valid had eligibility not ended;

2. The Employee is Totally Disabled when eligibility ends;

3. Confinement starts during the Total Disability for up to ninety (90) days following the date eligibility ends;

4. Treatment, exams or surgery takes place within ninety (90) days from the date eligibility ends;

5. The confinement, treatment, exam or surgery is needed to treat the Sickness or Injury causing Total Disability; and

6. The surgery, exam, service or confinement occurs during Total Disability.

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.

A. BARGAINING EMPLOYEES, NON-BARGAINING EMPLOYEES AND RETIREES

Subject to the Continuation Coverage rules under COBRA, a Bargaining Unit Employee's benefits automatically end on the first of the following dates:

1. The date this Plan ends;

2. The end of the period for which any required Contribution has not been made and 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) 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.

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 end of the period for which any required Contribution has not been made and 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; or

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.

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.

B. DEPENDENTS

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 end of the period 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:

        i. Is not able to work because of mental retardation or physical handicap;

        ii. 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

        iii. 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.

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.

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 date at the end 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; or

6. The end of the period for which any type of Contributions have been made, if required.

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.

C. 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:

1. Any loss, expense, or charge incurred as a result of such act, practice, omission, or misrepresentation; and

2. 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:

1. Timely update his or her enrollment status;

2. Report to this Plan:

   a. His or her divorce;

   b. His or her legal separation;

   c. The death of a Dependent;

   d. His or her loss of custody of a Dependent child; of

   e. A Dependent's attainment of a limiting age.

3. Satisfy your notification responsibilities under this Plan, including those in the Subsection entitled "Notification Obligations" of this; or

4. 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.

D. NOTIFICATION OBLIGATION

An Eligible Individual <u>must</u> notify the Fund Office of any event or change in circumstances that affect:

1. **Any Eligible Individual's eligibility for coverage under the Plan; or**

2. **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.

GENERAL PLAN PROVISIONS

A. 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.

B. FREE CHOICE OF PHYSICIAN

You have free choice of any Physician who meets this Plan's definition of a Physician.

C. 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.

D. SUBROGATION AND REIMBURSEMENT

1. Introduction

The Plan has first priority subrogation and reimbursement rights if it provides benefits resulting from or related to an injury, occurrence or condition for which the Eligible Individual has a right of redress against any Third-Party.

What do first priority rights of subrogation and reimbursement mean? They mean that if the Plan pays benefits 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 (D) constitutes the full and complete plan document language and is not a Summary Plan Description (SPD).

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. 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.

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. When a recovery is obtained, the recovery proceeds are held in trust for the Plan. The Plan then imposes a constructive trust or equitable lien on the recovery proceeds and is paid 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 action and 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 whether the claims for benefits relate to the recovery. If the Plan initiates an equitable action for reimbursement, the Plan is seeing 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 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 or causes of action the Eligible Individual has or may have 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 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 may be denied if the Eligible Individual does not cooperate with 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, 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.

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 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 reimburse the Plan for the attorneys' fees.

E. 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 participants who were Covered Under The Plan at the time of the Plan termination.

F. 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.

G. 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.

H. 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.

I. 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.

J. GENETIC INFORMATION NONDISCRIMINATION ACT

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

K. 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.

L. 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.

M. COVERAGE UNDER ANOTHER HEALTH CARE PLAN

You must advise the Plan Administrator 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.

N. 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:

1. The Eligible Individual who received the excess payment;

2. Any individual or provider to whom the payment was made;

3. Any insurance company, service plan, or any other organization which should have made payment; or

4. By offsetting payment of future benefits otherwise payable by this Plan until the overpayment is recovered.

MEDICAL DATA PRIVACY & SECURITY

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:

1. The Plan's uses and disclosures of Protected Health Information ("PHI");

2. Your privacy rights with respect to your PHI;

3. The Plan's duties with respect to your PHI;

4. Your right to file a complaint with the Plan and the Secretary of the U.S. Department of Health and Human Services; and

5. The individual or office to contact for further information about the Plan's privacy practices.

A. 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.

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.

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 precertification, 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:

i. 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;

ii. Reviewing the competency or qualifications of health care professionals; evaluating provider performance; accreditation, certification, licensing or credentialing activities;

iii. Underwriting, premium rating and other activities relating to creating, renewing or replacing a health insurance contract (or reinsurance) or health benefits under the Plan;

iv. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

v. 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

vi. Management and general administrative activities of the Plan, including, but not limited to:

I. Managing activities related to implementing and complying with the Privacy Regulations;

II. Resolving claim appeals and other internal grievances;

III. Merging or consolidating the Plan with another plan, including related due diligence; and

IV. As permitted under the Privacy Regulations, creating de-identified health information or a limited data set.

B. 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.

C. 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:

1. Not use or further disclose PHI other than as permitted or required by the Summary Plan Description or as required by law;

2. 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;

3. Not use or disclose PHI for employment-related actions and decisions unless authorized by the individual who is the subject of the PHI;

4. 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;

5. Report to the Plan any PHI use or disclosure that is inconsistent with the allowed uses or disclosures of which it becomes aware;

6. Make PHI available to an individual who is the subject of the information according to the Privacy Regulation's requirements;

7. Make PHI available for amendment and incorporate any amendments to PHI according to the requirements of the Privacy Regulations;

8. Make available the PHI required to provide an accounting of disclosures;

9. 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;

10. 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

11. Effective April 20, 2005, 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.

D. 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:

1. 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.

2. 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.

E. 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.

F. 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.

G. 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 Plan Administrator and ask to speak with the Plan's Contact Person.

HIPAA SECURITY

INTRODUCTION

Recently, the federal Department of Health and Human Services adopted regulations governing the Plan's obligation to maintain the security of your health information. The regulations arose from HIPAA. These regulations work in conjunction with the Privacy Regulations, which provisions are contained in a previous amendment to the Plan effective April 14, 2003. While the Plan has always taken care to secure your health information, the new 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.

A. POLICIES TO PROTECT PHI IN ELECTRONIC FORM

The Plan, along with the Plan Administrator, 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.

B. 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.

C. 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.

D. IF YOU HAVE ANY QUESTIONS

The Plan Administrator is largely responsible for maintaining the security of your PHI in electronic form. The Plan Administrator 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 Plan Administrator.

YOUR RIGHTS UNDER ERISA

As a participant in South Central Minnesota Electrical Workers' Family Health Plan, you are entitled to certain rights and protections under the ERISA. ERISA provides that all Plan participants will be entitled to:

A. RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine, without charge, at the Plan Administrator'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 Plan Administrator, 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 Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

B. 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.

C. PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and Beneficiaries. No one, including your Employer, your Union, or any other 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.

D. 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.

E. 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.

INFORMATION ABOUT YOUR PLAN

A. NAME AND TYPE OF PLAN

The name of your Plan is the South Central 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.

B. 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 names and addresses of the individual Trustees are listed in the front of this booklet. The address of the third-party Plan Administrator the Trustees have hired to help administer the Plan is:

Alan Sturm & Associates, Inc.
8120 Penn Avenue South,Suite 500
Bloomington, MN 55431
(952) 835-3035 / (800) 247-0401

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 Plan participants and Beneficiaries upon written request to the Plan Administrator. Copies are also available for examination by Plan participants and Beneficiaries at the office of the Plan Administrator.

Participants and Beneficiaries may receive, from the Plan Administrator, 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.

C. SERVICE OF LEGAL PROCESS

The Plan's agent for service of legal process is:

Ms. Jenny Buettner
South Central Minnesota Electrical Workers' Family Health Plan
Alan Sturm & Associates, Inc.
8120 Penn Avenue South, Suite 500
Bloomington, MN 55431

Service of legal process may also be made on any Trustee.

D. 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.

E. 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.

F. 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.

G. 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.

H. QUALIFIED MEDICAL CHILD SUPPORT ORDER ("QMCSO") PROCEDURES

Participants and Beneficiaries can obtain, without charge from the Plan Administrator, a copy of the Plan's procedures concerning QMCSOs.

I. PREFERRED PROVIDER NETWORK DIRECTORY

A directory of the providers in the Plan's Preferred Provider Network will be furnished to you, automatically, without charge, in a separate document when you become eligible under the Plan. A copy of the directory can also be obtained from Blue Cross Blue Shield of Minnesota.

J. WEBSITE

www.MyPrime.com (for mail order prescription drugs)

K. TELEPHONE NUMBERS

Fund Office	(952) 835-3035 or 1-800-247-0401
Prime Therapeutics (Prescription Mail Order)	1-877-357-7463
BCBSMN (Employee Assistance Program)	(651) 662-0900 or 1-800-432-5155

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