SUMMARY OF MATERIAL MODIFICATIONS
TO THE
SOUTH CENTRAL MINNESOTA ELECTRICAL WORKERS' FAMILY HEALTH PLAN
(2015 Restatement)

IMPORTANT NOTICE TO PLAN PARTICIPANTS AND BENEFICIARIES

The Trustees of the South Central Minnesota Electrical Workers' Family Health Plan (Plan) have amended the Plan as indicated below. The new language and provisions are more fully explained in the attached replacement pages for the Plan Document/Summary Plan Description (PD/SPD).

Effective August 1, 2014: The Plan is amended to increase the maximum withdrawal limit under the Premium Credit Accounts Reimbursement Program to $6,000 per family, per calendar year for Employees who are actively working in Covered Employment or actively seeking work in Covered Employment.

Effective July 1, 2015: The Plan is amended to allow Retirees and certain other Covered individuals who are not in active employment nor seeking active employment to use the balance of their Premium Credit Account for reimbursement even if the balance is less than three months' worth of coverage. The maximum withdrawal limit for Retirees and certain other Covered Individuals who are not in active employment nor seeking active employment is $4,999 per family, per calendar year.

Effective September 1, 2015: The Plan is amended to update the coverage provisions under the Replacement of Organ and Tissue Benefit to provide coverage for the following if certain requirements are satisfied: skin transplants; small-bowel and small-bowel live transplants; ventricular assist devices when used as a bridge to heart transplantation or bridge to recovery in patients with certain potentially reversible conditions; total artificial hearts when use as a bridge to heart transplantation; and certain other organ and transplant related expenses.

Please update your copy of the Plan Document to reflect the August 26, 2015 Amendments. Insert the attached replacement pages 70, 71, 72, 73, 73A, 89 and 89A.

This notice merely summarizes changes to the Plan. You should not rely on this notice to determine your benefits. Contact the Plan Administrator, Alan Sturm & Associates, Inc., at (800) 247-0401 or (952) 835-3035 if you have any questions.

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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

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

1. **Approved Procedures Not Subject to Special Requirements**

Charges incurred for kidney (excluding kidneys from live donors) and cornea transplants are approved for coverage if they (i) are Medically Necessary (which requires, among other things, that the transplants are not Experimental or Investigative) and (ii) are payable under all other provisions of this Plan Document. Kidney transplant (other than kidneys from a live donor) and cornea transplant procedures are not subject to the Special Requirements for Transplant Procedures discussed in Paragraph 3. below.

2. **Approved Procedures Subject to Special Requirements**

The following transplant procedures are approved for coverage if they: (i) are Medically Necessary (which requires, among other things, that the procedures are not Experimental or Investigative); (ii) are payable under all other provisions of this Plan Document; and (iii) meet the Special Requirements for Transplant Procedures in Paragraph 3. below:

a. Heart transplants;

b. Kidney transplants from a live donor;

c. Heart-lung transplants;

d. Liver transplants;

e. Skin transplants;

f. Lung transplants (single or double);

g. Pancreas transplant for:

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;

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

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

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

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

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 a request for authorization is made, the Plan Administrator will identify the Plan's case manager assigned to the transplant procedure.

c. Covered Medical Expenses incurred for services and supplies related to organ and tissue acquisition, including tissue typing and surgical, storage and transportation costs, are limited to a maximum benefit of $20,000, unless the services and supplies are provided by a healthcare provider designated by Blue Cross Blue Shield as a Blue Distinction Center for Transplants (BDCT).

d. If the transplant recipient is covered by this Plan, but the donor is not, medical expenses of the donor will be eligible for payment by the Plan, but

only to the extent they are not covered by any other plan of benefits. Weekly Disability Benefits are not payable to an organ or tissue donor who is not an active participant under this Plan.

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

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

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

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

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

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

g. Out-of-Hospital food and lodging expenses incurred in connection with the transplantation procedures are payable for charges of up to $200 per day per person incurred on behalf of the recipient, one member of the recipient's family, the live donor, and, if the live donor is a minor, one member of the live donor's family. The maximum benefit payable for food and lodging expenses is $5,000 per person per transplant procedure. These expenses will be reimbursed only to the extent valid receipts are provided to the Plan. This benefit is only applicable to recipients and live donors who live more than 100 miles from the facility where the transplant procedure will occur.

4. **Excluded Expenses**

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

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 the transplant.

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

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

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

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

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

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

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

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

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

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

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:

1. Have not already been detected by the Plan Administrator or reported by the provider; and

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

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

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

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

3. Have copies of the correct billing sent to the 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

PREMIUM CREDIT ACCOUNTS REIMBURSEMENT PROGRAM

Due to the Plan's deductible, coinsurance, and copayment requirements, you are responsible for paying a portion of many Covered Medical Expenses you and your Dependents incur. Similarly, you may be required to pay the dental and vision expenses you and your Dependents incur because the Plan does not cover dental and vision expenses. Subject to the requirements and conditions in this Section, you may use the Premium Credit Accounts Reimbursement Program to reimburse these types of expenses.

A. EMPLOYEES ACTIVELY WORKING IN COVERED EMPLOYMENT OR ACTIVELY SEEKING WORK IN COVERED EMPLOYMENT

This Subsection A. applies to Employees who are actively working in Covered Employment or actively seeking work in Covered Employment. If your Premium Credit Account has more Premium Credits than the amount needed to pay for three (3) months of coverage, you can use the excess Premium Credits to be reimbursed for any portion of Covered Medical Expenses, dental expenses, 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 $6,000 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 below the amount needed to pay for three (3) months of coverage.

B. RETIREES AND COVERED INDIVIDUALS WHO ARE NOT ACTIVELY WORKING IN COVERED EMPLOYMENT AND NOT ACTIVELY SEEKING WORK IN COVERED EMPLOYMENT

This Subsection B. applies to (1) Retirees and (2) Covered individuals who are not actively working in Covered Employment and not actively seeking work in Covered Employment, whether or not they have applied for retirement.

If you have a balance in your Premium Credit Account, you may use your Premium Credit Account to be reimbursed for any portion of Covered Medical Expenses, dental expenses, vision expenses, or co-premiums on your Spouse's Health Plan that you or your Dependents must pay even if the reimbursement depletes your Premium Credit Account below the amount needed to pay for three (3) months of coverage. To use Premium Credits to pay co-premiums on your Spouse's Health Plan, you must first submit documentation 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 $4,999 in Premium Credits each calendar year for reimbursement under the Premium Credit Accounts Reimbursement Program. You also may draw your Premium Credit Account to zero so long as the total of your reimbursements during a calendar year does not exceed the calendar year maximum.

C. SUBMITTING A CLAIM FOR REIMBURSEMENT

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 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.