SUMMARY OF MATERIAL MODIFICATIONS
TO THE
PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
OF THE
I.B.E.W. 292 HEALTH CARE PLAN
(2015 Restatement)

IMPORTANT NOTICE TO PLAN PARTICIPANTS AND BENEFICIARIES

The Board of Trustees has amended the Plan Document and Summary Plan Description ("SPD"). This notice summarizes the change and its effective date.

Amendment No. 26, Effective Date October 1, 2019.

The SPD was amended to update the current contact information for the Plan Administrator, Plan Auditor, Plan Counsel, and all new Trustees who have been appointed to the Board.

The SPD was amended to provide updated contact information for the vision benefit provider.

Amendment No. 27, Effective Date October 2, 2019.

The SPD was amended to provide coverage for bariatric surgery.

Amendment No. 28, Effective Date January 21, 2020.

The SPD was amended to clarify the definition of an active Member for purposes of eligibility for Retiree benefits.

Amendment No. 29, Effective Date September 1, 2019.

The SPD was amended to provide coverage for thirty-month well-child exams.

Amendment No. 31, Effective Date November 20, 2019.

The SPD was amended to clarify the deadline for receiving Claim Information Request Forms and the non-payment of claims that are over one year old.

Amendment No. 33, Effective Date January 1, 2020.

The SPD was amended to remove the language regarding the Health Club Discount Program.

Amendment No. 34, Effective Date April 1, 2020.

The SPD was amended to exclude Walmart and Sam's Club from the Prescription Drug Benefit network.

Please retain this notice with your current copy of the Plan Document and Summary Plan Description and insert the attached Plan contact information page and slip pages 26, 27, 32, 33, 48, 48A, 73, 90, 91, 91A, 102, and 116 to replace the current page of the same number. If you have any questions about the Plan, contact the Fund Office at (763) 493-8830 or 1-800-368-9045.

THE BOARD OF TRUSTEES
OF THE
I.B.E.W. 292 HEALTH CARE PLAN

Management Trustees:

Ms. Laura Karow (**Secretary**)
Gunnar Electric, Inc.
14850 Martin Drive
Eden Prairie, MN 55344

Mr. David Manderson
Minneapolis Chapter, NECA
1660 Highway 100 South, Suite 200
St. Louis Park, MN 55416

Mr. Paul Kosmides
Olympiatech Electrical
13700 Water Tower Circle
Plymouth, MN 55441

Mr. Jerry Hein (Alternate)
ECSI System Integrators
7900 Chicago Ave S
Bloomington, MN 55420

Union Trustees:

Mr. Dan Ferguson **(Chairman)**
I.B.E.W. Local 292
312 Central Ave SE, Suite 292
Minneapolis, MN 55414

Mr. David Frary
I.B.E.W. Local 292
312 Central Ave SE, Suite 292
Minneapolis, MN 55414

Mr. Jeffrey Heimerl
I.B.E.W. Local 292
312 Central Ave SE, Suite 292
Minneapolis, MN 55414

Ms. Jennifer Mudge (Alternate)
I.B.E.W. Local 292
312 Central Ave SE, Suite 292
Minneapolis, MN 55414

Plan Administrator:

Ms. Carla Gruetzmacher
Electrical Workers Local 292 Fringe Benefit Plans
6900 Wedgwood Road North, Suite 425
Maple Grove, MN 55311

Plan Counsel :

Ms. Cindy L. Davis
Kutak Rock LLP
60 South Sixth Street Suite 3400
Minneapolis, MN 55402

Plan Auditor:

Ms. Stacy A. Meyer, CPA
CliftonLarsonAllen LLP
220 South Sixth Street, Suite 300
Minneapolis, MN 55402

Plan Investment Consultant:

Mr. John Hume
Marco Consulting
25 Braintree Hill Office Park, Suite 103
Braintree, MA 02184

Plan Consultant:

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

Please contact the Fund Office at (763) 493-8830 or 1-800-368-9045 if you have any questions about this Plan. Information is also available at www.ibew292benefits.org.

	In-Network	Out-of-Network
Maternity Benefits	85% of Covered Expenses	75% of Covered Expenses

- Maternity expenses for delivery in a Hospital and for Medically Necessary services and supplies related to the delivery in a birthing center or at home, including the services of a licensed midwife instead of a Physician. If an In-Network provider is used and the expectant mother actively participates in the Blue Cross Blue Shield "A Healthy Start" Program®, for the duration of the pregnancy, a greater benefit (85% of Covered Expenses) is paid than if the mother does not actively participate in the program for the duration of the pregnancy (75% of Covered Expenses);
- ***Note:*** *Group health plans and health insurance issuers generally 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 48 hours following a vaginal delivery, or less than 96 hours following a caesarean section. 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 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).*

Inpatient Physician's Expense Benefit	**In-Network**	**Out-of-Network**
Physician Services	85% of Covered Expenses	75% of Covered Expenses
Inpatient and Outpatient Surgical Procedures	**In-Network**	**Out-of-Network**
Inpatient and Outpatient Surgical procedures	85% of Covered Expenses	75% of Covered Expenses
Expenses related to 2nd surgical opinion, if required by the Plan	100% of Covered Expenses	100% of Covered Expenses

- If the Eligible Individual wants a second surgical opinion, the benefit level will depend *upon* whether In-Network (Blue Cross Blue Shield) or Out-of-Network providers are used.
- *Certain* surgical procedures may be required to be performed on an outpatient basis. Contact Blue Cross Care Management if you have questions about the procedures that must be performed on an outpatient basis.
- If a Medically Necessary surgical procedure is required by the Plan to be performed on an outpatient basis, but is not performed on an outpatient basis, benefits will only be payable at 70% of the Covered Expense.
- Bariatric surgical expenses will be a covered benefit provided the procedure is consistent with the Blue Cross Blue Shield of Minnesota Medical Policy IV-19-005 and if performed at an accredited Bariatric Center of Excellence (a Blue Cross Blue Shield "Blue Distinction" provider).

Dental Coverage for Dependent Children

- Subject to an annual maximum of $2,500, the Plan will provide coverage for inpatient dental and facility charges, including anesthesia, for an Eligible Dependent Child under the age of twenty-six (26), for repairs or treatment of significant complexity (such as for the condition of baby bottle syndrome) if one or more of the following are present:
  - The Eligible Dependent exhibits physical, intellectual or medically compromising conditions such as mental retardation, cerebral palsy, epilepsy or cardiac problems, for which dental treatment under local anesthesia will not be expected to provide a successful result and which, under anesthesia, can be expected to produce a successful result;
  - Local anesthesia will not be successful because the Eligible Dependent suffers from acute infection, anatomic variations, or allergies; or
  - The Eligible Dependent has sustained extensive oral-facial and/or dental trauma, for which treatment under local anesthesia will be compromised.
- Associated dental expenses are subject to the conditions and limitations established in the *Section* entitled "Dental Coverage."

Prescription Drug Benefit

Prescription drugs will not be covered by the Plan unless they are purchased at a Prime Therapeutics pharmacy or through the Prime Therapeutics mail-order service. If an Eligible Individual goes to non-network pharmacy, the Eligible Individual must submit the claim to Prime Therapeutics for reimbursement. You can contact Prime Therapeutics at 877-357-7463. To locate a Prime Therapeutics pharmacy, Call 1-800-509-0545. Beginning April 1, 2020, non-network pharmacies include Walmart and Sam's Club. For inquiries on or after April 1, 2020, visit www.savrx.com or call 1-866-233-IBEW (4239).

Retail:	
Brand Name	$9.00 minimum co-pay or 20% of the cost over $9.00 up to a maximum of $50.00 total per prescription for up to a 90-day maximum supply (subject to the Pharmacy's ability to fill a 90-day maximum supply).
Generic	$5.00 minimum co-pay or 20% of the cost over $5.00 up to a maximum of $25.00 total per prescription for up to a 90-day maximum supply (subject to the Pharmacy's ability to fill a 90-day maximum supply).
Mail Order:	
Brand Name	$18.00 minimum co-pay or 10% of the cost over $18.00 up to a maximum of $100.00 total per prescription for up to a 90-day maximum supply.
Generic	$10.00 minimum co-pay or 10% of the cost over $10.00 up to a maximum of $50.00 for up to a 90-day supply.

Custom Molded Orthotic Appliances* (only 1 pair/Calendar Year) The second and later orthoses will be covered subject to 100% co-insurance. The Eligible Individual must pay the full cost of the orthotic, but will receive the Plan's discounted in-network pricing.	85% of Covered Expenses	75% of Covered Expenses
Jobe's Stockings	75% - Two pair per Calendar Year as Medically Necessary, Deductible Does Not Apply	
	In-Network	**Out-Of-Network**
Speech Therapy	85% of Covered Expenses	75% of Covered Expenses
Speech therapy is therapy that is prescribed to: (1) restore the ability to express thoughts, speak words, and form sentences to a person who once had that ability but lost that ability as a result of disease or Injury; or (2) treat a delay in the development of the ability to express thoughts, speak words, and form sentences as a result of a congenital defect. Since this is a limited benefit, you may want to work with a Dependent Child's school to access available speech therapy services before accessing the Plan.		
Developmental Delay Therapy Services	The Plan covers physical, occupational and speech therapy services provided for Eligible Dependents for the treatment of developmental delay.	
Infertility	$1,500 per pregnancy, limited to associated office visits outpatient Hospital services, laboratory tests, in-patient services, and artificial and intrauterine insemination procedures, but in no event covering prescription drugs.	
Wig to Cover Hair Loss Resulting From Chemotherapy and/or Alopecia Areata	Chemotherapy and Radiation Therapy Patients: $350 Every 2 Calendar Years Alopecia Areata: $1,200 every 2 Calendar Years No Deductible Applies	
Genetic Testing (including Amniocentesis)	Testing for one genetic condition per Eligible Individual, per Calendar Year	
Wellness/Routine Examinations	**In-Network**	**Out-of-Network**
Physical Examination	100% of Covered Expenses for one health maintenance visit per Calendar Year subject to: • Plan's out-of-pocket maximum provision The Physical Examination Benefit will cover the following: a pap smear (cytology/cytologic test) Prostate Specific Antigen (PSA) blood test, mammogram (for Eligible Individuals), cholesterol and blood glucose screening, screening test for fecal occult blood	

	(guaiac lab test, stool sample SNA test and/or fecal immunochemical test (FOBT)), biometric screening, skin cancer screening, immunizations and vaccinations. In addition to one health maintenance visit per Calendar Year, the Plan also pays 100% of Covered Expenses, subject to the Plan's out-of-pocket maximum provision, for a thirty-month well-child exam.	
Health Dynamics Preventive Care Program Exam	Health Dynamics provides an annual Preventive Care Exam at no cost to Participants and their spouses. Participants who complete the exam will receive a $100 credit towards their annual deductible. If both a Participant and their spouse complete the exam within the same year, they will receive a $300 credit towards their annual deductible. Credits applied towards an annual deductible will be available for use in the Plan Year following the year in which the exams were completed. For example, if a Participant and spouse complete the Preventive Care Exam on October 1, 2019, they will receive a $300 credit towards their annual deductible for the 2020 Plan Year beginning May 1, 2020.	
In-home healthcare visit for newborn Dependent (1 visit)	85% of Covered Expenses	75% of Covered Expenses
Women Age 40 and Over	100% of Covered Expenses for one health maintenance mammogram per Calendar Year	
Routine Colonoscopy (one screening every three years for Eligible Individuals who are age 50 or older or who have a clinical family history of colon disease)	85% of Covered Expenses	75% of Covered Expenses
Smoking Cessation Drugs	To receive smoking cessation benefits the Eligible Individual must be enrolled and actively participate in the Blue Cross Blue Shield of Minnesota Blue Print for Health Stop Smoking Program®. Prescription drugs for smoking cessation will be covered through the Plan's prescription drug benefit.	
Diabetes Management Education	Diabetes Management Education – up to a life time maximum of three courses of diabetes management or $1,500.	
Celiac Disease	Celiac Disease Nutritional Education – a lifetime maximum of one course of up to a maximum of $500	
Hearing Aids	After you meet the deductible, the Plan will pay 80% of the Covered Expenses for up to $1,500 per ear every five Calendar Years if proven to be Medically Necessary by an audiogram*. (Replacement ear pieces are covered as Medically Necessary)	
Hearing Aid Screening	85% of a screening once per Calendar Year.	

*If an audiogram shows that more frequent replacement is necessary due to a change in medical condition, the cost for those replacements may be covered. An audiologist's report must be sent to the Fund Office before any hearing aid purchase will be authorized. Contact the Fund Office with any questions.

4. Retire directly from Covered Employment at any age because of a Permanent and Total Disability that occurred while covered under the Plan.

If you are on any out-of-work lists maintained by any local union affiliated with the I.B.E.W., you are not considered retired and are not eligible for retiree benefits under this Plan.

For purposes of eligibility for Retiree benefits:

1. An active Member means any individual who meets the following:
    a. On or before November 30, 2020:
        i. Retires directly from Covered Employment; or
        ii. Retires directly because of Permanent and Total Disability.
    b. On or after December 1, 2020:
        i. Retires directly from Covered Employment;
        ii. Retires directly because of Permanent and Total Disability;
        iii. Maintains eligibility through Self-Contributions; or
        iv. Maintains eligibility under the COBRA Continuation Coverage provisions of the Plan for Non-Bargaining Unit Employees and Limited Energy Agreement Bargaining Unit Employees.

2. Permanent and Total Disability means official written determination of the Social Security Administration that the Eligible Employee suffers from a mental or physical condition that qualifies you for disability benefits under the federal Social Security Act as amended (or would qualify you when any waiting period for those benefits expires). The Active Employee must provide the Fund Office a copy of the written determination of disability from the Social Security Administration. If an Eligible Employee establishes a Permanent and Total Disability, eligibility for retiree benefits will begin no sooner than the date the Fund Office receives that determination and will not be retroactive to any time before that date.

3. "Alternative Employment" means a position which is not covered by the Plan but which is (i) covered by a Collective Bargaining Agreement between the employer and the Union, or (ii) is within the electrical industry, with the employer being signatory to a Collective Bargaining Agreement with the Union, but only so long as the Eligible Member and his or her Eligible Dependents are continuously covered by a group health plan maintained by that employer and only so long as the Member maintained without interruption membership in the Union.

4. The Member also must advise the Plan prior to entering Alternative Employment and provide any information or evidence which the Plan may require to substantiate Alternative Employment.

Years Under the Plan

You must also have had at least five (5) Years Under the Plan, before retirement. Your Years Under the Plan will:

1. Be the equivalent of your Years of Credited Service under the Electrical Workers Local No. 292 Pension Plan, if your employment was covered by a Collective Bargaining Agreement requiring employer hourly contributions to this Plan;

2. Be the equivalent of your years of coverage under this Plan, if your employment was covered by a Collective Bargaining Agreement or other agreement requiring the employer to make monthly premium payments to the Plan;

3. Be the equivalent of your years in Alternative Employment as you substantiate to the Trustees' satisfaction, if you were employed in Alternative Employment. Periods of employment before your first participation in the Plan will be determined to be Alternative Employment or not regardless of whether you gave the Plan prior notice of entering alternative employment;

4. Be the equivalent of your years working for a Union-affiliated employer as you substantiate to the Trustees' satisfaction, if you were Participant in the Plan during the entire time you were employed by a Union-affiliated employer. You must give the Plan prior notice in order to maintain retiree eligibility; and

5. Also include years of coverage by the South Central Minnesota Electrical Workers Health and Welfare Fund, as you substantiate to the Trustees' satisfaction, if you were previously covered under the South Central Minnesota Electrical Workers Health and Welfare Fund and then became covered without interruption by this Plan due to the transfer of a portion of Local 343's territorial jurisdiction to Local 292 in 1998.

- With certain conditions of Anisometropia; or
- With certain conditions of Keratoconus.

Doctors must obtain prior approval from VSP for Medically-Necessary contact lenses.

Filing a Claim for Vision Benefits

Using VSP Doctors

When you visit a VSP doctor, you do not need to present a benefit card and do not need to complete any forms. Simply identify yourself as a VSP plan Eligible Individual, and you will receive benefits in the form of discounts on supplies and services.

Using Out-of-Network Providers

An Eligible Individual has the option of seeing an out-of-network provider. For out-of-network reimbursement, an Eligible Individual pays the entire bill when services are received, then send the following information to VSP:

- An itemized receipt listing the services received;
- The name, address and phone number of the out-of-network provider;
- The Eligible Employee's Social Security number or member identification number;
- The Eligible Employee's name, phone number and address;
- The name of the group;
- The patient's name, date of birth, phone number and address; and
- The patient's relationship to the Eligible Employee (such as "self," "spouse," "child," etc.).

Claims must be submitted to VSP within six months from the date of service. Please keep a copy of the information for your records and send the originals to the following address:

VSP
P.O. Box 385018
Birmingham, AL 35238-5018

If you'd like more information about the out-of-network schedule, please contact the Fund Office.

Limitations and Exclusions

This Vision Care Benefit is designed to encourage Eligible Individuals to maintain healthy eyes as a part of your regular health care routine. It does not cover options chosen for

the Plan. (Children under age 26 are not required to have been covered under the Plan when the accident occurred.);

a. Correction of congenital defects;

b. Surgery to reconstruct a breast following a mastectomy procedure on the affected breast and: (1) any surgical procedure on the non-affected breast which is intended to provide a symmetrical appearance; (2) any costs for prostheses related to the mastectomy procedure (i.e. implants, special bras); and (3) the treatment of any physical complications associated with the mastectomy procedure;

c. Corrective surgical procedures on body organs which perform or function improperly; or

d. Voluntary vasectomies, tubal ligations, and other sterilization procedures for Employees, Retirees and Dependent Spouses.

10. Any treatment, care, services or supplies which are not recommended or approved by the attending Physician.

11. Services or supplies received from a Physician or Hospital that does not meet this Plan's definition of a Physician or a Hospital.

12. Any service, supply, treatment or procedure which is not given for the treatment or correction of, or in connection with, a specific non-occupational Injury or Sickness, including for a condition based on family history unless specifically Covered under the Plan.

13. Reversal of, or attempts to reverse, a previous elective sterilization.

14. Charges incurred for hormone therapy, artificial insemination, or any other direct attempt to induce or facilitate fertility or conception. Nonetheless, the Plan will cover up to the dollar limit specified in the Schedule of Benefits for both Spouses per pregnancy for the treatment of infertility. This benefit will be limited to associated office visits, outpatient hospital services, laboratory tests, inpatient services and artificial and intrauterine insemination procedures but in no event will the benefit extend to prescription drugs.

15. Any operation or treatment in connection with sex transformations or any type of sexual dysfunction, including any complications arising from this care, except for claims for the restoration of sexual function lost due to organic or psychogenic causes.

16. Charges incurred in connection with voluntary abortion. (This exclusion does not apply to an abortion performed on an Eligible Individual whose pregnancy is the result of rape as evidenced by a police report, an abortion where the life of the mother is at imminent

risk, or an abortion which is therapeutic in nature and has prior approval by the Plan Administrator).

17. Charges incurred by an Eligible Dependent Child for a vasectomy, tubal ligation or other sterilization procedure unless recommended by a Physician for therapeutic proposes.

18. Any expenses incurred for services, supplies or treatments that are not prescribed by a Physician or a nurse practitioner.

19. Drugs or medicines not legally dispensed by a registered pharmacist at a pharmacy according to the written prescription of a Physician.

20. Drugs or medicines prescribed by a Physician or nurse practitioner which are available as over-the-counter purchases (for example, aspirin, cough medicine or vitamins, nutritional supplements, cough medicine, Nicorette gum, cosmetics, soap, toothpaste, etc.).

21. Any and all compound drugs or medicines, whether prescription or nonprescription.

22. Any care or treatment of an Eligible Family Member provided by a person who is a relative in any way to the Eligible Employee, Eligible Retiree or Eligible Dependent who is receiving the care, or who ordinarily lives in the home of the Eligible Employee, Eligible Retiree, or Eligible Dependent who is receiving the care.

23. Any expense for physical therapy or any other 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 (except benefits provided under the Hospice Care Program).

24. Any charge for speech therapy (except as specifically stated in the "Covered Medical Expenses" section of this Summary Plan Description).

25. Special education or training provided to an Eligible Individual, regardless of the type or purpose of the education, the recommendation of the attending Physician, the qualifications of the attending Physician or the qualifications of the person providing the education (except for one course for diabetes management education up to the applicable lifetime maximum benefit for Non-Essential health benefits specified in the Schedule of Benefits).

26. Any charge for eye refractions, eyeglasses, contact lenses (except the first pair of contact lenses required following cataract surgery), or dental prosthetic appliances, including charges made for the fitting of any of these appliances, unless the service or supply was given as a result of non-occupational bodily injury which occurred while the individual was Covered Under the Plan or unless the service or supply is covered under the vision care or dental and orthodontia expense benefits.

27. Any expense for completing claim forms (or any forms required by the Plan for the processing of claims) by a Physician or other provider of medical services or supplies.

28. Nursery charges beyond the hospitalization of mother and newborn child or after the end of the period for which the mother or newborn child is medically required to remain in the Hospital. In determining a mother's maximum period of medically required

requirement applicable to the treatment for which the Allowable Expense was incurred; and

- The benefits that would be payable for the Allowable Expenses under the Other Plans, in the absence of provisions with a purpose like that of these COB provisions, whether or not a claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the Other Plans do not total more than those Allowable Expenses.

More Information on Coordination of Benefits

The following rules also apply to claims eligible for coordination of benefits:

- Benefits are coordinated on all Eligible Individual claims;
- The Fund Office may release or receive necessary information about Eligible Individual claims to or from other sources. All Eligible Individuals must furnish the Fund Office with any information it requests to process a claim on a Claim Information Request Form provided by the Fund Office. Claim Information Request Forms must be returned to the Fund Office within forty-five (45) days. If the Claim Information Request Form is not received by the Fund Office within forty-five (45) days, the claim and any related claims will be denied.
- Benefits are paid for "Allowable Expenses," which means expenses that are eligible under This Plan to be considered for payment;
- All Eligible Individuals must file a claim for any benefits the Eligible Individual is entitled to from any other source. Your Plan benefits will be calculated as if the Eligible Individual received benefits from the other sources (whether or not the Eligible Individual files a claim with those sources);
- Benefits are coordinated with Other Plans, including other Blue Cross Blue Shield group plans and individual plans paid for by the Eligible Individual. Benefits are also coordinated with Medicare. If an Eligible Individual is covered under another health plan or policy, contact the Fund Office to find out whether that fits the definition of Other Plan; and
- If other insurance is lost or terminated, the Eligible Individual must notify the Fund Office and provide proof of the loss (such as a Certificate of Prior Health Coverage). Benefits will be delayed or denied until the required proof is provided.
- The "Working Spouse Rule" as described under the Benefit Eligibility section.

Facility of Benefit Payment

Whenever payments which should have been made under this Plan in accordance with this Section have been made under any other plans, the Trustees have the right, exercisable alone and in their sole discretion, to pay over to any organization making such payments any amounts the Trustees determine to be warranted in order to satisfy the intent of this Coordination of Benefits Section.

- If the Plan relied on an internal rule, guideline or protocol in making the decision, provide a description of such rule, guideline or protocol;
- If the claim decision was based on a medical necessity or experimental treatment exclusion, provide an explanation of the scientific or clinical judgment relied upon for the determination; and
- If your claim for benefits is denied based upon a disability determination, the notice will provide an explanation of the basis for agreeing or disagreeing with the following:
  - The views presented by the Claimant to the Plan of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;
  - The review of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
  - A disability determination regarding the Claimant made by the Social Security Administration if such determination is presented by the Claimant to the Plan.

Right to Appeal

Any Claimant who applies for benefits under this Plan and is ruled ineligible or not qualified by the Trustees (or by an authorized representative acting for the Trustees) or who believes he or she did not receive the full amount of benefits to which he or she is entitled, or who is otherwise adversely affected by any action of the Trustees or their authorized representatives, has the right to file an appeal.

No Claimant may assign any right to appeal benefit denials or any causes of action that may arise after the denial of benefits to any person or entity, including a provider. Any attempt to do so will be null and void.

Appeal Procedure

- A Claimant wishing to appeal a denial of benefits, and/or the Claimant's authorized representative, must file the Claimant's appeal in writing at the Fund Office not more than one hundred eighty (180) days after the date on which notice of the action which is being appealed was mailed to the Claimant's last known address. Mail the written claim appeal to Plan Administrator Carla Gruetzmacher, I.B.E.W. 292 Health Care Plan, 6900 Wedgwood Road North, Suite 425, Maple Grove, MN 55311, (763) 416-6196 (fax), or (763) 493-8830 (phone).
- The Claimant has the right to compose a claim appeal which explains why the Claimant believes the claim should be reviewed.
- The Claimant has the right to attach any additional information which the Claimant believes will help a favorable decision to be made on the Claimant's claim.