I.B.E.W. 292 HEALTH CARE PLAN

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

AMENDED AND RESTATED EFFECTIVE MAY 1, 2022

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

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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.

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"). 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 (763)493-8830 or 1-800-368-9045. 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.

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BENEFITS AT-A-GLANCE

This handbook is both the Plan Document and Summary Plan Description of the Plan. There is not a separate official Plan Document, so this handbook is the place to look for information about your benefits. Eligible Individuals and Beneficiaries should not rely upon any oral description of the Plan, because the written terms of this handbook and other governing documents which may be in effect will always govern.

This handbook is current as of May 1, 2022.

What's Included in the I.B.E.W. 292 Health Care Plan

The I.B.E.W. 292 Health Care Plan (the "Plan") is really an assortment of benefits including: medical, dental, prescription drug, vision, loss of time, accidental death and dismemberment, and life insurance benefits. These benefits are offered to you because your Employer has agreed to participate in the Plan. Some groups of Eligible Individuals only have access to some of these benefits. If you have questions about your benefits, please contact the Fund Office at: IBEW 292 Benefits, 6900 Wedgwood Road North, Suite 425, Maple Grove, MN 55311, or by phone at (763) 493-8830.

How Plan Benefits are Provided

Your Employer contributes funds to cover the cost of your coverage under the Plan. These Employer Contributions are based on: (1) a percentage of your earnings; or (2) a pre-set amount. Once you have worked a certain number of hours or have met other conditions your Employer requires, you become eligible for coverage.

Benefit Summaries

Following are summaries of some of the benefits offered under the Plan. For more information, refer to the corresponding section listed in the Table of Contents.

Medical Coverage

You and your Eligible Dependents may receive Plan benefits for covered services regardless of whether you see a health care provider who participates in the United Healthcare Choice Plus Network (an "in-network" provider) or any other provider (an "out-of-network" provider). If you choose an in-network provider, however, you will frequently enjoy better plan benefits, such as a lower coinsurance percentage, lower deductible, and lower maximum out-of-pocket limit.

Claims for covered services incurred by you or your Eligible Dependent through December 31, 2020 for an ongoing course of treatment that began prior to April 1, 2020, with a provider that was a Blue Cross Blue Shield in-network provider on April 1, 2020 but is a United Healthcare out-of-network provider, will be covered at in-network cost share levels based on usual and customary amounts established by the Plan.

Effective May 1, 2022, subject to the Plan's standard cost sharing requirements and coordination of benefits rules, the Plan will cover certain claims for items and services provided by out-of- network providers as if the items and services were provided by in-network providers. This rule applies only to: (i) claims for Emergency Services provided by an out-of-network

provider and/or at a non-Participating Health Care Facility; (ii) claims for certain non-Emergency Services furnished to you by an out-of-network provider at a Participating Health Care Facility; and (iii) claims for out-of-network Air Ambulance Services. The exact costs payable by you and the Plan for such claims will be determined in accordance with the rules and regulations established and in effect at the time the services are provided pursuant to the Consolidated Appropriations Act, 2021.

Dental Coverage

Delta Dental Plan of Minnesota is the state's largest provider of dental benefits, covering over 1,000,000 Minnesotans. You and your Eligible Dependents may see any Dentist you choose. However, you'll usually receive a higher level of benefits when you use a participating Delta Dental provider.

Delta Dental Plan of Minnesota has two networks providing benefits to Eligible Individuals:

- **Delta Premier Network**. The Delta Premier Network is a statewide network that includes over 96% of Dentists in Minnesota; and
- **Delta Preferred Network**. The Delta Preferred Network is a subset of the Premier network in which over 800 Dentists have given greater discounts on services. If you see a Delta Preferred Dentist, you will have lower out-of-pocket expenses.

Non-Participating Providers. If you have access to Delta Dentists and choose to use another Dentist instead, your benefit may be significantly different than if services were provided by a Delta Dentist. This may result in higher out-of-pocket expenses for you.

Vision Care

Vision care is offered through Vision Service Plan (VSP). You may choose to see any Doctor you wish under this Plan. Again, if you choose non-participating providers, your benefits may differ substantially.

- **VSP Doctors**. A network of participating Doctors through which eye exams, lenses and frames can be obtained.

- **Non-Participating Providers**. All out-of-network providers.

- **Safety Eyewear**. All commercial, residential, inside construction, maintenance, and Limited Energy Agreement Bargaining Unit Employees are eligible for safety eyewear benefits. Contact the Fund Office for the current covered provider. Call the Fund Office for claim forms before scheduling an appointment with the provider.

Loss of Time Benefits

Loss of time benefits are also called “weekly income” or “disability” benefits. These benefits are provided to you when you become Totally Disabled and meet other criteria for this benefit. These benefits are payable for up to fifty-two (52) weeks per occurrence of Total Disability and subject to a one hundred four (104) week lifetime maximum. Your Plan premiums are credited during a period of Total Disability, subject to a fifty-two (52) week cap per occurrence of Total Disability and a lifetime maximum of one hundred four (104) weeks. These benefits will run concurrently with any workers’ compensation benefits and will be reduced by any workers’

compensation benefits or retirement benefits you will receive from a pension plan negotiated or sponsored by the I.B.E.W.

Maternity Leave Benefits

Maternity leave benefits are provided to eligible female Bargaining Unit Employees performing Covered Employment in connection with the Employee's pregnancy and childbirth upon application approved by the Trustees and certification by a Physician of physical or mental limitations requiring maternity leave. The Plan makes two types of maternity leave benefits available to eligible female Bargaining Unit Employees: Pre-Delivery Health and Safety Leave and Post-Delivery Recovery Leave wage replacement benefits. Maternity leave benefits are subject to an aggregate lifetime cap of fifty (50) weeks. Maternity leave benefits may not be received on an intermittent basis and are subject to coordination with other wage replacement benefits as described further in the Maternity Leave Benefits section of this Plan.

Accidental Death and Dismemberment Benefits

Accidental death and dismemberment benefits are provided to you through the Plan. These benefits are provided to protect you in the event of the loss of your limbs or eyes.

Life Insurance Benefits

- **Employee Life Insurance Benefit.** Eligible Employees participating in the Plan are eligible for life insurance coverage, although the amount of coverage begins to decrease at age 65.

- **Dependent Life Insurance Benefit**. If you are an Employee participating in the Plan, your Spouse is also eligible for life insurance coverage. Each of your Dependent children covered under the Plan are eligible or life insurance coverage, but only up to the Eligible Child's 26th birthday.

BENEFIT ELIGIBILITY

Initial Eligibility – Initial eligibility is established either through being: (1) a Bargaining Unit Employee; or (2) an actively-employed Non-Bargaining Unit Employee of an Employer who has signed a contribution agreement with the Plan.

The following charts show the Plan's initial eligibility rules for various groups. The information in these charts applies to medical, dental, prescription drug, vision, loss of time, maternity leave, accidental death and dismemberment, and life insurance benefits. In all of the following situations, coverage begins on the first of the month after the Fund Office receives the required premiums.

See the following list and the "Definitions" Section of this booklet for definitions applicable to this Section:

Bargaining Unit Employee – An Employee who is a member of a collective bargaining unit represented by the Union and who is an Employee of an Employer who has agreed to make Contributions to the Plan on the Employee's behalf.

Non-Bargaining Unit Employee – An Employee who is not a member of any collective bargaining unit represented by the Union and is employed full-time by an Employer.

Premium Credits – The amount of dollars contributed and reported by an Employer for the hours worked by a Member in accordance with the Inside Agreement. Premium Credits are applied to provide eligibility for Members and their Dependents. Premium Credits cannot be converted to cash. The amount of Premium Credits include up to four hours per day credit that is provided by the Plan on behalf of apprentices with verified attendance at the apprenticeship school.

Premium Credit Account – A bookkeeping account established for all Members under the Inside Agreement in order to determine eligibility and to determine if premium payments are required in order to continue Employee Benefits. If a Member works *more* than the required hours to maintain coverage under the Plan, the Contribution dollars in excess of that required amount are put into the Premium Credit Account of the Member, up to a maximum of nine months' of premium. **Note**: There is a lifetime maximum of nine months' worth of Premium Credits that can be spent on Retiree coverage (see the "Using Your Premium Credit Account for Retiree Coverage" heading in the "Retiree Coverage" Section for more information).

Benefit Month – A period of one calendar month during which time an Employee is eligible for benefits as a result of having met the Initial Eligibility or Continuing Eligibility rules during the corresponding Eligibility Month.

Eligibility Month – A period of one calendar month during which an Employee meets the Initial Eligibility rules to provide eligibility for Plan benefits during the corresponding Benefit Month.

Members Covered Under the Inside Agreement	
New Members	A Member is eligible under the Plan on the first day of the Benefit Month immediately following the Eligibility Month in which the Member: ♦ Has been hired by a Contributing Employer in the jurisdiction as a Bargaining Unit Employee working under the Inside Agreement; and ♦ Has established a Premium Credit balance equal to one hundred thirty (130) hours of Contributions then in effect for the Local 292 collective bargaining agreement metro area or the 12-County Area [and one hundred thirty (130) hours of Contributions outside of the Local 292 metro area, under the Inside Agreement]. The "12 County Area" means all of Hennepin, Carver and Scott Counties, and all that part of Anoka County containing these cities: Andover, Anoka, Columbia Heights, Coon Rapids, Fridley, Hilltop, Ramsey and Spring Lake Park; all of Wright County and that portion of Benton and Sherburne Counties east of State Highway 25 to Highway 10 and an imaginary line straight west to the Mississippi River. In order to be considered a "New Member" under this eligibility rule, a Member must (a) have not been eligible for coverage under this Plan as a Bargaining Unit Employee covered under the Inside Agreement for five (5) or more years prior to the commencement or resumption of Bargaining Unit work covered under the Inside Agreement; and (b) not be transferring from another I.B.E.W.-NECA health care plan.
Former Members Rehired Within Five Years	Except as described below regarding former Members who re-establish Plan eligibility immediately following a period of COBRA Continuation Coverage, a Member who was eligible for coverage under this Plan in the past five (5) years will again be eligible for benefits on the first day of the Benefit Month ***immediately following*** **the Eligibility Month in which**: ♦ the Member has been hired by a Contributing Employer as a Bargaining Unit Employee working under the Inside Agreement; *and* ♦ the Member has established a Premium Credit balance equal to one month's premium under the Plan.

Former Members Maintaining COBRA Continuation Coverage Under the Plan that Ends During the Period of April Through September 2021	A former Member maintaining coverage under the Plan from April through September 2021 by means of COBRA Continuation Coverage can re-establish eligibility for coverage under the Plan through Self-Contributions as of the first day of the month immediately following termination of the Member's COBRA between April and September 30, 2021 if (a) the former Member signs—prior to the termination of the former Member's period of COBRA Continuation Coverage for a reason other than non-payment—and remains on the "out-of-work" book maintained by the Union hiring hall; (b) the former Member has maintained continuous coverage under the Plan; and (c) the former Member is not otherwise ineligible under the Plan. The former Member must become Covered under the Plan through Self-Contributions (and the Member's COBRA Continuation Coverage will end) on the first day of the month immediately following a period of COBRA Continuation Coverage that ends during the period from April through September 2021.
Members Transferring from Another I.B.E.W.-NECA NECA Health Care Plan	If a Member transferred from another I.B.E.W.-NECA health care plan, the Member will become eligible on the first day of the Benefit Month following the Eligibility Month in which the Member has established a Premium Credit Balance equal to six months' premiums under the Plan.
Bargaining Unit Employee Covered Under Any Other Agreement	
Bargaining Agreement Employee	Bargaining Unit Employees working under a Collective Bargaining Agreement that is not an Inside Agreement ("Bargaining Agreement Employees") will become eligible under the Plan on the first day of the Benefit Month following the Eligibility Month in which: ♦ the Bargaining Agreement Employee completes and files enrollment information with the Fund office; and ♦ the Employer timely pays and the Plan has received the necessary Contribution before the first day of the month for which coverage is to be effective.
Non-Bargaining Unit Employees of Employers Signatory to A Participation Agreement with the Plan	
Employee	A Non-Bargaining Unit Employee will become eligible for coverage on the first day of the Benefit Month immediately following the Eligibility Month in which: ♦ the Non-Bargaining Unit Employee completes and files enrollment information with the Fund Office; and ♦ The Plan has received the required Contribution before the first day of the month for which coverage is to be effective.

Dependents	Dependents of Non-Bargaining Unit Employees Covered under the Plan pursuant to a Participation Agreement will become eligible under the Plan on the first day on or after a Non-Bargaining Unit Employee's Initial Eligibility Date in which the Dependent(s) meet the Plan's definition of an Eligible Dependent and the Fund Office has accepted all required enrollment information.
Bargaining Unit Employees And Non-Bargaining Unit Employees Of Employers Signatory To A Participation Agreement With The Plan: Accumulated Service Eligibility For Medical Coverage Only	
Employee	A Bargaining Unit Employee or Non-Bargaining Unit Employee will become Covered under the Plan on the first day of the Benefit Month that begins two calendar months after the Eligibility Month in which: ♦ the Employee completes and files enrollment information with the Fund Office demonstrating to the satisfaction of the Plan that the Employee is currently employed by a contributing Employer in a classification under which the Employee could receive coverage from the Plan under its other eligibility provisions, and that the Employee has accumulated 1,200 hours of service with the Employee's current Employer (excluding hours of service accumulated prior to a period of 26 weeks or more during which the Employee was not employed the Employer); and, ♦ the Plan receives the required Contribution as established by the Trustees for the first month for which coverage is to be effective. The Employee may only continue coverage under this eligibility provision while the Employee remains employed in a classification under which the Employee could otherwise receive coverage from the Plan by the Employer for whom the Employee worked when the Employee became eligible. Coverage under this eligibility provision consists of Medical Coverage only. To continue coverage the Employee must pay each month the amount required by the Trustees regardless of any Contributions the Employer makes on the Employee's behalf. If the Employee ceases to be eligible after commencing coverage under this eligibility provision and before becoming eligible under another eligibility provision, the Employee may continue coverage only as provided in the section of this Plan entitled "Coverage under COBRA." Any Premium Credits the Plan receives with respect to the Employee during a period in which the Employee is Covered under this eligibility provision count toward meeting the Plan's other eligibility requirements. If the Employee receives coverage under this eligibility provision and subsequently meets the requirements for coverage under another eligibility provision, the terms of the Employee's coverage will be governed by the Plan's other eligibility provision beginning at the time that coverage would have commenced under the other provision.

Dependents	The Dependents, including Spouses, of Members and Non-Bargaining Unit Employees who are Covered by this Plan and satisfy this eligibility provision will be retroactively Covered by the Plan beginning on the first day of the calendar month in which: ♦ the Employee has filed enrollment information with the Fund Office that it, in its sole discretion, determines is complete and acceptable, identifying the Participant's Eligible Dependent(s), including Spouse; available spousal coverage; and any other information that the Plan Trustees determine, in their sole discretion, is required for enrollment.

Continuing Eligibility

Except as described in the Retiree Coverage and Continuation Coverage sections of this Plan, once you become eligible under the Plan, you and your Eligible Dependents will continue to be Covered for Plan benefits if you meet certain conditions (or rules) as follows:

Members Covered Under the Inside Agreement	
Eligibility through Contributions and Premium Credit Account	A Member will remain eligible for benefits under the Plan if: ♦ The Member remains actively employed as a Bargaining Unit Employee covered by the Inside Agreement, and ♦ The Member has accumulated enough Premium Credits in the Benefit Month before the month in which coverage is sought. The Trustees establish the amount of Premium Credits necessary to maintain coverage under the Plan. A Member who loses employment with a Contributing Employer and is actively available and seeking work (as evidenced by the Member signing the "out-of-work" book maintained by the Union hiring hall), may continue coverage under this Plan without a lapse by application of the Member's Premium Credits credited to the Member's Premium Credit Account or, as further indicated below, by paying Self-Contributions. Until December 31, 2022, a Member who is referred to a Contributing Employer, but who has no work hours for which employer Contributions are due to the Plan on behalf of the Member may continue coverage under this Plan for two consecutive months without a lapse in coverage by application of the Member's Premium Credits without signing the "out-of-work" book. If, however, the Member has not signed the "out-of-work" book by the end of the two consecutive months of Plan coverage maintained by application of the Member's Premium Credits without any employer Contributions to the Plan on behalf of the Member, the Member's Premium Credit Account will be frozen and Member's Plan coverage will be terminated. This provision is no longer in effect as of January 1, 2023. During a period of National or State emergency, as determined in the

	sole discretion of the Trustees, a Member who is referred to a Contributing Employer but has no work hours for which employer Contributions are due to the Plan on behalf of the Member, may, without signing the "out-of-work" book, continue coverage under this Plan without a lapse in coverage by application of the Member's Premium Credits credited to the Member's Premium Credit account or, as further indicated below, by paying Self-Contributions. **Important Note**: Since eligibility is always on a "whole-month" basis, the premium must be received from your Employer in the month *prior* to the month for which coverage is required in order to be added to your Premium Credit Account.
Self – Contributions	If a Member does not have enough Premium Credits to maintain coverage, the Member can maintain coverage by timely paying Self-Contributions to the Plan in the amount necessary to maintain coverage (after the Member's Premium Credits, if any, have been first applied to the cost). Effective February 1, 2022, payments made in-person, by email, or by fax must be received by the Fund Office by 3:00 p.m. on the last day of the month. Payments made by mail must be postmarked by the last day of the month. In order to be eligible to make Self-Contributions, a Member must also: ♦ Not be referred by the Union to a job which is not covered by the Collective Bargaining Agreement (see the limited exception below); ♦ Not be eligible to participate in the Retiree Program at retirement; and ♦ Be actively available and seeking work as evidenced by records of the Union hiring hall. The following additional rules apply for Self-Contributions: ♦ The amount of Self-Contributions is determined from time to time by the Trustees; ♦ The Plan will notify the Member in writing of the Self-Contributions amount necessary to continue eligibility. • After receiving Employer remittance reports for a given month, the Fund Office will notify Eligible Members whose Premium Credits are insufficient to provide more than one month of additional coverage unless additional Employer Contributions are received in the next month, that a Self-Contribution will be required to continue coverage for the second full month following the date of the notice. • After receiving Employer remittance reports for a given month (for calendar months beginning more than one

	calendar month after your Initial Eligibility Date), those Eligible Members who do not have enough Premium Credits to provide coverage for the following month will be issued a Self-Contribution billing for the following month. This notice will provide Eligible Members with the option of deducting the Self-Contribution amount from a certain portion of their account balances under the Electrical Workers Local No. 292 Defined Contribution and 401(k) Plan or the Supplemental Unemployment Benefits Plan. In any event, coverage will stop on the 1st day of the month if the Member has not yet made the Self-Contribution for that month but will be retroactive to that 1st day if you pay before the end of that month. ♦ If a Member loses coverage by failing to make the required Self-Contributions, the Member will not be eligible for coverage again until the 1st day of the month following the month you establish a Premium Credit balance equal to one (1) month's premium.

Inside Construction Members Referred to a Non-Contributing Employer	If you are a Member who is temporarily employed by a non-contributing employer, you will remain eligible for benefits under this section as long as the following requirements are met: ♦ You must be referred by the Union to an employer who does not meet this Plan's definition of an Employer; ♦ The Plan Administrator must be informed of the employment by a non-contributing employer; ♦ Your employment with the non-contributing employer must be "temporary"; ♦ Your Premium Credit Account is applied to continuing coverage under this Plan; ♦ You timely pay the Self-Contribution amount minus the amount of Premium Credits applied to the cost of coverage under this Plan; ♦ If you transfer to the non-contributing employer or become permanently employed by the same non-contributing employer and, as a result, become covered by the non-contributing employer's group health plan, you can maintain your Premium Credit Account until you are employed by a Contributing Employer to this Plan; ♦ If you lose coverage under this Plan by failing to make the required Self-Contributions, you will be required to reestablish your eligibility in this Plan as a Bargaining Unit Employee covered by the Inside Agreement; and ♦ If you are Covered by this Plan, lose employment with a non-contributing employer and are actively available and seeking work (as evidenced by records of the Union hiring hall), you may continue coverage under this Plan without a lapse by application of any available Premium Credits or by paying Self-Contributions.

Members Covered Under Any Other Agreement	
Continuing Eligibility	Non-bargaining unit Employees of Employers signatory to the Inside Agreement will remain eligible as long as: ♦ Your Employer remains a Contributing Employer; and ♦ The Plan receives the necessary Contributions on your behalf in the necessary amount by the due date specified by the Trustees.
Non-Bargaining Unit Employees of Employers Signatory to the Inside Agreement	
Continuing Eligibility	Non-bargaining unit Employees of Employers to any other Agreement with the Plan will remain eligible as long as: ♦ Your Employer remains a Contributing Employer; ♦ You remain actively employed for the Contributing Employer; ♦ The Plan receives the necessary Contributions by the due date specified by the Trustees; and ♦ The Trustees have not been required to terminate participation of your Employer in order to preserve the Plan's integrity or tax exempt status.
Non-Bargaining Unit Employees of Employers Signatory to Any Other Agreement with the Plan	
Continuing Eligibility	Your eligibility will continue as long as: ♦ Your Employer remains a Contributing Employer; ♦ You remain actively employed for the Contributing Employer; ♦ The Plan receives the necessary Contributions on your behalf in the necessary amount by the due date specified by the Trustees; and ♦ The Trustees have not been required to terminate participation of your Employer in order to preserve the Plan's integrity or tax exempt status.
Non-Bargaining Unit Employees that transition to Bargaining Unit Employees with Employers Signatory to an Agreement with the Plan	
If you are a Non-Bargaining Unit Employee and transition to a Bargaining Unit Employee with a Contributing Employer, you may make premium self-payments to maintain coverage until you work sufficient hours to re-establish eligibility, so long as: ♦ You have been continuously covered under the Plan since you established initial eligibility to participate in the Plan; ♦ Your Employer remains a Contributing Employer;	

- You remain actively employed for the Contributing Employer;
- The Plan receives the necessary Contributions on your behalf in the necessary amount by the due date specified by the Trustees; and
- The Trustees have not been required to terminate participation of your Employer in order to preserve the Plan's integrity or tax exempt status.

Layoffs	Laid Off Eligible Individual Married to Active Eligible Individual
	♦ If an Eligible Individual is laid off but is also married to another Eligible Individual who is <u>not</u> laid off, the laid off Eligible Individual may elect to freeze their coverage and Premium Credits, and maintain coverage under the Plan as a Dependent. ♦ To elect this option, the Eligible Individual must contact the Fund Office to elect the option to freeze his or her coverage and Premium Credits and to be Covered as a Dependent.
	Married Eligible Individuals Laid Off at the Same Time
	♦ If two Eligible Individuals are married to one another and are laid off at the same time (either simultaneously or at different times), the Eligible Individuals have the option of staggering the use of their available Premium Credits so as to use one Eligible Individual's Premium Credits first, followed by the use of the other Eligible Individual's Premium Credits, if such use is necessary. ♦ If one of the Eligible Individuals once again becomes eligible for Plan coverage based upon Contributions, the other Eligible Individual, who remains laid off, may be Covered as a Dependent Spouse, and any remaining Premium Credits of either Eligible Individual will be frozen. ♦ If both Eligible Individuals remain laid off upon exhaustion of all available Premium Credits, the Eligible Individuals will then have the ability to continue their coverage through Self-Contributions and COBRA Continuation Coverage as provided elsewhere in the Plan. Eligible Individuals must contact the Fund Office to elect this option and specify the order of Premium Credit usage.
	Laid Off or Unemployed Eligible Individual with Spouse that has coverage under another employer health plan
	♦ If an Eligible Individual is laid off or experienced a change in status and has signed the out-of-work book, and their Spouse has coverage through another employer's health plan, the Eligible Individual may opt-out of coverage under this Plan, freeze their Premium Credit Account and enroll for coverage under his or her Spouse's group health plan.

	♦ The Eligible Individual must contact the Fund Office and provide a certificate of current coverage from their Spouse's group health plan to take advantage of this opt-out provision. ♦ The Eligible Individual must return to coverage under this Plan if Contributions are made on the Eligible Individual's behalf. ♦ The Eligible Individual may return to coverage under the Plan if they or their Spouse lose coverage under the Spouse's group health plan ♦ To return to coverage, the Eligible Individual must apply for reinstatement with the Fund Office. The Eligible Individual must provide proof satisfactory to the Plan that the Eligible Individual and their Eligible Dependents have been continuously covered under the Spouse's group health plan from the date of termination of coverage under this Plan until the date of reinstatement.
Employees Covered Under Accumulated Service Eligibility For Medical Coverage Only	
Continuing Eligibility	Employees Covered under the provision of this Plan entitled "Accumulated Service Eligibility For Medical Coverage Only" will remain eligible as long as: ♦ Your Employer remains a Contributing Employer; ♦ You remain actively employed (in a classification under which you could receive coverage from the Plan under its other eligibility conditions) for the Contributing Employer for whom you worked when you became eligible; ♦ The Plan receives from you the necessary Contributions by the due date specified by the Trustees; and ♦ The Trustees have not been required to terminate participation of your Employer in order to preserve the Plan's integrity or tax exempt status.

Please note that an Employee will be considered "actively employed" for eligibility purposes through the last day of the month for which the Contributing Employer makes their final timely Contributions on behalf of the Employee.

Eligibility During Disability

♦ Member

- Disability Occurring During Self-Contribution Eligibility. If you are an Eligible Member and become Totally Disabled while your eligibility for Plan benefits is being maintained, you will be entitled to disability benefit credits under this "Eligibility During Disability" section.

- Non-Occupational Disability. If you are a Member who is Totally Disabled as a result of a non-occupational Injury or Sickness and unable to accumulate the required

number of Premium Credits from employment to maintain eligibility for benefits, you will be granted disability benefit credits during the period of your Total Disability according to the following:

- You must meet each of the following requirements:
  - You must already be eligible for benefits in the Benefit Month in which you become Totally Disabled;
  - You must have enough Premium Credits or employer Contributions in the Eligibility Month in which you become Totally Disabled to satisfy the Continuing Eligibility provisions to make you eligible for benefits under the Plan in the corresponding Benefit Month. These Premium Credits or employer Contributions can be from accumulated Premium Credits or employer Contributions under the Continuing Eligibility provisions or from credited disability hours in the Eligibility Month in which you become Totally Disabled, or from a combination of accumulated Premium Credits or employer Contributions from working and credited disability Premium Credits or employer Contributions during the Eligibility Month in which you become Totally Disabled; and
  - You must not have commenced retirement benefits from the Electrical Workers Local No.292 Pension Plan or the Electrical Workers Local 292 Defined Contribution and 401(k) Plan.
- You must provide the Trustees with medical proof acceptable to the Trustees of your Total Disability.
- You will be credited with disability credits for each day that you are Totally Disabled that falls on a normal work day of the week, including Saturdays and Sundays.
- The disability credits granted to you will be used as regular Premium Credits in determining your eligibility.
- The maximum period that your eligibility may be continued under this provision is fifty-two (52) weeks for any single period of Total Disability (one hundred four (104) week lifetime maximum) following the last Benefit Month for which you were eligible due to accumulated Premium Credits under the Continuing Eligibility provisions of the Plan.
- If you recover from your Total Disability after having been Covered under this provision and you do not return to employment for a Contributing Employer, your benefits will terminate on the date you are no longer Disabled or the date your eligibility terminates according to Plan's other eligibility rules, whichever occurs first.
- If you continue to be Totally Disabled or exhaust your disability benefits under the Plan and you do not return to Covered Work after having been Covered under this Eligibility During Disability provision for the maximum allowable period, you may use up to two months of Premium Credits or continue to make Self-Contributions for two months to maintain coverage under the Plan. After

this period, if you do not meet the requirements of the applicable Continuing Eligibility provision in this Plan Document, your ability to continue Plan coverage will be governed by the Continuation Coverage under the COBRA Continuation Coverage provisions of the Plan.

► If you are an Eligible Employee covered under a collective bargaining agreement negotiated by Local 292 Bargaining Unit Member who (1) continues to be Totally Disabled or has exhaust your disability benefits under the Plan, (2) does not immediately return to work in the electrical industry within the jurisdiction of Local No. 292 after having been Covered under this Eligibility During Disability provision for the maximum allowable period, and (3) is not eligible to earn Premium Credits under your applicable Local No. 292 collective bargaining agreement, you may continue your Plan coverage in accordance with the applicable Continuing Eligibility provision in this SPD. If you do not satisfy each of the requirements in the applicable Continuing Eligibility provision in this Plan Document, your continued Plan coverage will be governed by the Continuation Coverage under the COBRA Continuation Coverage provisions of the Plan.

► You will be credited with a maximum of forty (40) Pension Credits per week under the Electrical Workers Local No. 292 Pension Plan for a maximum of one hundred four (104) weeks of disability.

► You may elect to be paid a gross benefit of three hundred dollars ($300) per week under the Electrical Workers Local No. 292 Supplemental Unemployment Benefit Plan after six weeks of Total Disability.

- Occupational Disability. If you are a Bargaining Unit Employee and become Totally Disabled as the result of an occupational Injury or Sickness that occurs while working for a Contributing Employer under a Collective Bargaining Agreement, these Eligibility During Disability provisions will apply to you as though the disability occurred as a result of non-occupational Injury or Sickness. This benefit is paid for a maximum period of fifty-two (52) weeks for any single period of Total Disability and a total of one hundred four (104) weeks lifetime maximum. You may also elect to be paid a gross benefit of three hundred dollars ($300) per week from your account under the Electrical Workers Local No. 292 Supplemental Unemployment Benefit Plan after six (6) weeks of the Total Disability after any single period of Total Disability. In any event, you will not be eligible for this benefit unless you first provide the Fund Office a copy of the first report of Injury as well as a copy of each check stub that is attached to each of your monthly worker's compensation payments.

♦ Non-Bargaining Unit Employees

- If you are a Non-Bargaining Unit Employee Covered under this Plan, you will be provided with Plan coverage in the absence of premium payments during your period of Total Disability for which disability benefits are paid under this Plan. This benefit is for a maximum of fifty-two (52) weeks for any single period of Total Disability and a total of one hundred four (104) weeks lifetime maximum.

- If you become Totally Disabled and unable to work as a result of occupational or non-occupational Injury or Sickness, you will continue to be eligible coverage under the Plan only as long as you continue to meet the applicable Continuing Eligibility

requirements of the Plan unless you elect to maintain eligibility under the COBRA Continuation Coverage provisions of the Plan.

Survivor Benefits

Surviving Dependents of Eligible Employees Covered Under the Plan

- If you are an Eligible Employee who has accrued at least twenty-four (24) months of eligibility and you die while eligible under this Plan, your Eligible Dependents will maintain coverage for six (6) calendar months following the month in which your death occurs.

- After the six (6) months, your Eligible Dependents will maintain eligibility under the Plan by using your Premium Credit Account until it is exhausted.

- After your Premium Credit Account is exhausted, your Eligible Dependents may elect, as an alternative to and lieu of COBRA, to continue coverage by making Self-Contributions until the first of the following occurs:

  - The date your surviving Spouse remarries;

  - The date your surviving Spouse or other Dependent become eligible for coverage under any other group health plan;

  - The date the Eligible Dependent no longer satisfies the Plan's definition of a Dependent;

  - The date your Spouse or Dependent becomes eligible for coverage under any governmental plan providing medical benefits, to the extent permitted by law; or

  - The date coverage could otherwise be terminated under the Plan.

Thereafter, your Eligible Dependent may be eligible for COBRA Continuation Coverage.

Pension Beneficiaries

If you are an otherwise Eligible Employee who receives or has received retirement benefits under the provisions of the Electrical Workers Local No. 292 Pension Plan or the Electrical Workers Local No. 292 Defined Contribution and 401(k) Plan, you will only be eligible for the coverage available to Retirees as described in the section entitled "Retiree Coverage." However, you will retain any Premium Credit Account balance accrued prior to the commencement of your Retiree coverage and such Premium Credits will apply towards the cost of your Retiree coverage.

Surviving Dependents of Retirees Under this Plan

If you die while you are Covered under this Plan as an Eligible Retiree, your Eligible Dependents who were Covered under this Plan from your retirement date until the date of your death may elect, as an alternative to and lieu of COBRA, to maintain coverage through payment of Self-Contributions.

In this case, your Eligible Dependents will be permitted to continue coverage by making Self-Contributions until the first of the following occurs:

- The date the Eligible Dependent no longer meets the Plan's definition of a Dependent;
- The date the Eligible Dependent marries;
- The date coverage for the Eligible Dependent could otherwise be terminated under the Plan;
- The date the Eligible Dependent becomes eligible for coverage under any other group health plan;
- The date your Eligible Dependent becomes eligible for coverage under any governmental plan providing medical benefits, to the extent permitted by law; or
- The date of the Eligible Dependent's death.

Reciprocity

I.B.E.W. 292 **Bargaining Unit Members** can work within the jurisdiction of another local of the I.B.E.W. and continue their eligibility for I.B.E.W. 292 Health Care Plan through reciprocity.

If you work for another I.B.E.W. local and enough health care premium credits are received either from the health care plan established by that other local or from your I.B.E.W. 292 premium credit account, your eligibility may be continued. If this situation applies to you, you must sign up on the Electronic Reciprocity Transfer System ("ERTS") at any local union office. Signing up will allow Contributions to be forwarded to the health care fund you select. The fund you select will notify you if it is not able to receive the Contributions.

Your Plan eligibility will be affected if you do not sign up on the ERTS. Your health care premium credits and/or Employer Contributions will be reciprocated consistent with the Electrical Industry Health and Welfare Reciprocal Agreement then in effect.

If you are not a bargaining unit member of I.B.E.W. Local 292, you must first accumulate six (6) months' worth of Premium Credits through employer Contributions to become eligible for coverage under this Plan.

Minnesota Portability Plan

If your home I.B.E.W. Local Union is a signatory to the Minnesota Portability Agreement and you are employed in the jurisdiction of another I.B.E.W. Local Union that is a signatory to the Minnesota Portability Agreement, the Minnesota Portability Agreement provides that your employer will report hours worked and send Contributions to the plan situated in the jurisdiction of your home I.B.E.W. Local Union. The Minnesota Portability Agreement assures that you receive credit in this Plan, for all work you perform within the jurisdiction of another signatory I.B.E.W. Local Union. 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 the work was performed. Those Contributions will then be handled according to the provisions for reciprocity of Contributions under the National Reciprocity Agreement.

Excessive Period of Unemployment Benefit

Bargaining Unit Employees of Employers signatory to the Inside Agreement and their Eligible Dependents are entitled to the Excessive Period of Unemployment Benefit during any Period of Excessive Unemployment as defined by and subject to the following provisions:

- **Effective Date of Benefit.** A Premium Credit Reserve Pool is available for use on the first day of the Benefit Month following the month for which the Trustees have made a determination that a Period of Excessive Unemployment exists. A Period of Excessive Unemployment will exist on the first day of the month immediately following the month in which, as of the end of the 16th day of the month, there are 375 or more Members on the hiring hall out of work book. Example: If on January 16th the hiring hall out of work book has 375 or more Members, Excessive Unemployment credits would commence on the February billing.

- **Eligibility Requirements.** Bargaining Unit Employees of Employers signatory to the Inside Agreement and their Eligible Dependents are eligible for the Excessive Period of Unemployment Benefit provided:

  - All accrued Premium Credits from the Bargaining Unit Employee's Premium Credit Account have been exhausted;

  - The Bargaining Unit Employee is in lay-off status and is actively seeking employment by evidence of being signatory to the Union's referral list;

  - The Bargaining Unit Employee is not working in the industry for a non-signatory employer and has not received permission from the Union to do so; and

  - The Bargaining Unit Employee has been Covered Under the Plan immediately prior to eligibility for the Excessive Period of Unemployment Benefit.

  If you are not a bargaining unit member of I.B.E.W. 292, you are not eligible to receive Excessive Period of Unemployment Benefits.

- **Continuing Coverage Under the Plan during Periods of Excessive Unemployment**

  - The Bargaining Unit Employee of an Employer signatory to the Inside Agreement may continue to be Covered Under the Plan during any Period of Excessive Unemployment by payment of Self-Contributions equal to the following:

    1. One-half (1/2) of the usual monthly Self-Contribution amount provided that the Bargaining Unit Employee remains “in compliance,” as defined below, with the Union’s hiring referral rules. This reduced monthly Self-Contribution amount is referred to as the “Premium Subsidy” Benefit in this Subsection.

    2. One hundred percent (100%) of the usual monthly Self-Contribution amount if the Bargaining Unit Employee is not “in compliance” with the Union’s hiring referral rules, as described below.

The term "in compliance" means the Bargaining Unit Employee has not violated any rules or procedures promulgated by the Union for purposes of administering the referral list (also known as "the book"), which would cause the Bargaining Unit Employee's entitlement to receive the Premium Subsidy Benefit to cease even though he or she remains on the Union's referral list. The rules and procedures may be modified from time to time; therefore, a Bargaining Unit Employee should contact his or her local Union to request and obtain information regarding the applicable rules and procedures currently in force.

- The applicable monthly Self-Contribution amounts will be determined by the Trustees and may be modified from time to time.

- The due date for all monthly Self-Contributions is any date that is established by the Board of Trustees.

- The Self-Contribution rate will remain one-half (1/2) of the monthly Self-Contribution rate then in effect through the first coverage month after the month in which the Bargaining Unit Employee returns to Covered Employment.

- **Termination of the Premium Credit Reserve Pool Benefit.** Benefits under the Premium Credit Reserve Pool will terminate upon the first to occur of the following events:

  - The first day of the month after the second full calendar month in which the Bargaining Unit Employee returns to work and is not on the out-of-work book, (i.e. if a Bargaining Unit Employee returns to work on June 15th, the Bargaining Unit Employee may make the Excessive Period of Unemployment Benefit payment for July (1/2 of the usual monthly Self-Contribution amount) and then in August, if working and not on the out-of-work book, will be required to make the full Self-Contribution payment);

  - The first day of the month immediately following the month in which, as of the end of the 16th day of the month, there are 300 or less Members on the hiring hall out of work book. Example: If on January 16th the hiring hall out of work book has 300 or fewer Members then no credit is given on the February billing;

  - The balance of the Premium Credit Reserve Pool is not sufficient to fund the benefit for all Eligible Individuals;

  - The date on which the Bargaining Unit Employee fails to timely make the required Self-Contribution; or

  - By action by the Board of Trustees, who retain full and complete authority and discretion to amend, modify, or terminate this benefit.

- **Termination of the Premium Subsidy and Cancellation of the Premium Credit Account.** The Participant's eligibility for the Premium Subsidy and Premium Credit Account as described in this Section will terminate if the following events occur:

  - Upon reasonable evidence that the Bargaining Unit Employee is working in the industry for a non-signatory employer and has not received permission from the

Union to do so. Termination of the Premium Subsidy will have an effective date designated by the Board of Trustees;

- A Bargaining Unit Employee's eligibility for the Premium Subsidy will terminate as of the date the Bargaining Unit Employee is no longer in compliance with the Union's hiring referral rules; or

- By action by the Board of Trustees, who retain full and complete authority and discretion to amend, modify, or terminate this benefit.

Freezing of Premium Credits for Individuals Who Work in a Related Industry

A Member who leaves Covered Employment and accepts a related position in the electrical industry (such as a position as an electrical inspector), may, in his or her sole discretion, elect to "freeze" any Premium Credits in his or her Premium Credit Account during such employment. These Premium Credits will then be used to re-establish his or her initial eligibility for Plan benefits when the Member subsequently satisfies the Plan's requirement for benefit eligibility. Any such request to "freeze" Premium Credits must be made on forms available from the Plan Administrator.

Freezing Premium Credits – Coverage from Employer Outside of Electrical Industry

A Member who is laid off and accepts a position outside of electrical industry work with an employer that sponsors a health plan, may elect to freeze his or her Premium Credit Account subject to the following:

- The Member must complete an election form to freeze their Premium Credits and provide written documentation evidencing other medical coverage.

- The Member must be employed outside electrical industry work. Work performed within the electrical industry will make the Member ineligible to freeze Premium Credits. For purposes of this provision, "electrical industry work" is defined as work:

  - That is subject to a collective bargaining agreement negotiated by, signed by, or otherwise involving the International Brotherhood of Electrical Workers (the "I.B.E.W.") or any of its affiliated local unions or any similar type of work (regardless of whether your particular work is the subject of any collective bargaining agreement);

  - That is considered Covered Employment, or that does or would entitle you to Contributions to or benefits under the Plan, or that is the kind of work performed by an individual who is Covered by (or is entitled to be Covered by) the Plan, or any similar type of work;

  - As an electrician for any federal, state, local, or other subdivision of government; or

  - For an employer that is signatory to a Collective Bargaining Agreement with the I.B.E.W. (or with any of its affiliated local unions), or for an employer that is not such a signatory but that is similar to the types of employers who are such signatories, if the work is in a supervisory, managerial, estimating, or other non-bargaining position.

- The Member must return to coverage under this Plan if Contributions are made on his or her behalf.

If Contributions are made on the Member's behalf, the freeze ends and Premium Credits will be applied, as needed, towards maintaining coverage under the Plan.

Enrollment of New Spouses and Dependents

There may be circumstances where you need to add Dependents to the Plan, after you have first enrolled for coverage. Specifically, if you get married or there is a birth or adoption of a new Dependent Child, you must notify the Plan Administrator within one hundred eighty (180) days of the marriage, birth or adoption to have coverage effective for the new Spouse or Dependent Child(ren) from the date of marriage, birth or adoption.

If notice is provided to the Plan Administrator more than one hundred eighty (180) days after the marriage, birth or adoption, you may still add your new Spouse and Dependent Child(ren) but coverage will only be effective as of the date that late notice is provided to the Plan Administrator.

Notwithstanding any other provision of the Plan to the contrary, effective April 1, 2009, an Eligible Employee may enroll in the Plan as required by HIPAA under either of the following circumstances:

- The Eligible 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 loss of eligibility for such coverage and the Eligible Employee requests coverage under the Plan not later than sixty (60) days after the date of termination of such coverage.

- The Eligible 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 Participant requests coverage under the Plan not later than sixty (60) days after the date the Eligible Employee or Dependent is determined to be eligible for such assistance.

An election change under this provision must be requested within sixty (60) days after the termination of Medicaid or state child health plan coverage or the determination of eligibility for a state premium assistance subsidy, as applicable.

Opt-Out for Health Savings Account (HSA) Coverage

A Dependent of an Eligible Individual may elect to opt-out of coverage under this Plan if the Dependent is eligible for a health plan offered by their employer that is a high deductible health plan with a Health Savings Account (HSA). The Dependent must complete a "Waiver of Coverage" form to opt-out of coverage under the Plan.

The Dependent and Eligible Individual understand that by electing to opt-out of coverage under the Plan, the Dependent will:

- Not be entitled to any benefits or other payments from the Plan, including, but not limited to, health care benefits, dental benefits, accidental death and disability benefits, extended coverage options under federal law, or Retiree benefits.

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

- Forfeit any right to benefits under the Plan even if Plan benefits are superior in some respects to the benefits under the plan offered by the Dependent's employer.

- Have no right to return to coverage under the Plan until such time as HSA and high-deductible health plan coverage is lost, or the Dependent otherwise meets the eligibility requirements of the Plan and provides written notice to the Trustees of the desire to once again become Covered by the Plan.

The "Waiver of Coverage" form can be obtained from the Plan Administrator. The Dependent must indicate the date upon which the waiver of coverage will be effective.

Working Spouse Rule

Effective January 1, 2018, employed Spouses who are eligible to enroll in Qualifying Employer Health Care Coverage through their employer for a cost of less than $250 per month for the lowest cost employee-only coverage option are required to enroll in such coverage in order to be eligible for Medical Coverage under the Plan. Upon proof of enrollment in such employer's group coverage in a form acceptable to the Trustees, the Spouse would be eligible for Medical Coverage under the Plan on a secondary basis. Any optional/voluntary benefit buy ups, if any (like vision, dental, or Spouse/child coverage additions), do not count towards the $250 threshold.

MEDICAL COVERAGE

If you have questions about the Medical Coverage under the Plan, please contact the Fund Office.

Freedom of Choice

You may choose either an "in-network" provider that participates in the United Healthcare Choice Plus network, or an "out-of-network" provider, which is any other provider. Choosing an in-network provider will generally give you a higher level of coverage and lower costs. The Plan's network is provided through United Healthcare. (Effective May 1, 2022, certain out-of-network services will be treated as in-network services as described more fully in the "No Surprises Act" topic at the end of this "Medical Coverage" section.)

Claims for covered services incurred by you or your Eligible Dependent through December 31, 2020 for an ongoing course of treatment that began prior to April 1, 2020, with a provider that was a Blue Cross Blue Shield in-network provider on April 1, 2020 but is a United Healthcare out-of-network provider, will be covered at in-network cost share levels based on usual and customary amounts established by the Plan.

Teladoc

Teladoc is a convenient, online health care service that lets you get virtual medical advice with no appointments. Through Teladoc, you can talk live to health care professionals who can answer questions, make online diagnoses, and prescribe medications. To access Teladoc visit https://www.teladoc.com.

Genetic Information Nondiscrimination Act

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

Consolidated Appropriations Act, 2021

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Consolidated Appropriations Act, 2021, including the No Surprises Act.

Schedule of Benefits

The Schedule of Benefits summarizes the medical benefits available to you and your Eligible Dependents for covered non-occupational Injuries or Illness. Occupational Illnesses or Injuries may also be covered by this Plan if you have signed a subrogation and reimbursement agreement and have been denied worker's compensation benefits. Contact the Fund Office if you have questions about coverage for occupational Injuries or Illnesses.

Any payments made on behalf of an Eligible Individual at any time during a Calendar Year under this Plan will be used in determining an Eligible Individual's remaining Calendar Year benefit.

Deductible		
A deductible is a predetermined amount, paid annually, before the Plan begins to provide payment. The medical deductible is on an individual and family basis. Two or more individual medical deductibles can be applied to the family medical deductibles. Deductibles do not apply to certain services such as medication management or diagnostic testing. Deductibles are included in the maximum out-of-pocket expense limits. If you satisfy any portion of the out-of-network deductible, it may be applied toward the in-network deductible. However, you may **not** apply any paid portion of an in-network deductible toward the out-of-network deductible. Coinsurance for prescription drugs does not count toward any deductible.*		
**Please note that effective May 1, 2022, certain out-of-network services will be treated as in-network services for cost sharing purposes pursuant to the No Surprises Act. Payments for such out-of-network services will be counted toward in-network deductibles and in-network maximum out-of-pocket limits (except for copayments, which do not count toward deductibles or maximum out-of-pocket limits, as noted below).*		
	In-Network	**Out-of-Network**
Member or Employee	$100*	$400*
Each Dependent	$100*	$400*
Family Maximum	$300*	$1,200*
Copayments		
*Copayments are amounts which Eligible Individuals pay before receiving services such as urgent care, doctor office visits or prescriptions. Copayments do **not** count toward deductibles or maximum out-of-pocket limits.*		
	In-Network	**Out-of-Network**
Injections classified under the CDC guidelines as routine with the exception of the shingles vaccination. The Plan will cover the shingles vaccination once per lifetime for Members who are 50 years of age and older.	None	None – but subject to deductible and coinsurance
Injections not classified as routine under the CDC guidelines	None	None – but subject to deductible and coinsurance
Office Visit (Specialist or Primary	$20	None – but subject to deductible and coinsurance
Urgent Care	$30 (facility charge subject to coinsurance)	None – but subject to deductible and coinsurance
MinuteClinic (or other similar types of clinics)	$10	None – but subject to deductible and coinsurance
Hospital Admissions	$60	None – but subject to deductible and coinsurance*

Please see the "No Surprises Act" topic at the end of this "Medical Coverage" section for important information regarding coverage of certain out-of-network items and services as in-network items and services effective May 1, 2022.

Emergency Services	$60 plus coinsurance equal to 25% of Covered Expenses, but only if you are not admitted	$60 plus coinsurance equal to 25% of Covered Expenses, but only if you are not admitted*

Please see the "No Surprises Act" topic at the end of this "Medical Coverage" section for important information regarding coverage of certain out-of-network items and services as in-network items and services effective May 1, 2022.

Coinsurance

Coinsurance is the percentage of the cost of Covered Expenses that each Eligible Individual must pay over and above any applicable deductibles and copayments before the Plan begins to pay benefits.

	In-Network	**Out-of-Network**
What the Plan Pays	85% of Reasonable and Customary Covered Expenses	75% of Reasonable and Customary Covered Expenses*
What You Pay	15% of Reasonable and Customary Expenses, and Charges the Plan Does not Cover	25% of Reasonable and Customary Covered Expenses, and Charges the Plan Does not Cover*

Please see the "No Surprises Act" topic at the end of this "Medical Coverage" section for important information regarding coverage of certain out-of-network items and services as in-network items and services effective May 1, 2022.

Maximum Out-of-Pocket Expense

Maximum out-of-pocket expense is the maximum dollar amount an Eligible Individual must pay in a Calendar Year for deductibles and coinsurance (other than coinsurance for prescription drugs). Neither coinsurance for prescription drugs nor copayments of any kind count toward reaching this maximum. After the Calendar Year maximum out-of-pocket amount is reached, the Plan pays 100% of Covered Medical Expenses for the rest of that year.

	In-Network	**Out-of-Network**
Per Person	$1,500	$3,500*
Per Family	$4,500	$10,500*

Please see the "No Surprises Act" topic at the end of this "Medical Coverage" section for important information regarding coverage of certain out-of-network items and services as in-network items and services effective May 1, 2022.

If you satisfy any portion of the out-of-network out-of-pocket expense, it may be applied toward any in-network out-of-pocket expense. However, you may not apply any in-network expense toward your out-of-network out-of-pocket expense.

Coinsurance for the following covered services will not be included in the maximum out-of-pocket expense:

- Prescriptions;
- Dental and orthodontia services;
- Vision care; and
- Routine exams.

Covered Medical Expenses

Covered Medical Expenses are the actual expenses incurred by an Eligible Individual upon the recommendation and approval of the attending Physician for the services, supplies and types of treatment listed below which are required in connection with the treatment of such Eligible Individual as a result of non-occupational bodily Injury or Sickness for which Plan benefits are payable, subject to the Schedule of Benefits and other Plan provisions, provided that the Plan may review and compare similar expenses.

The Plan may also pay occupational Illnesses or Injuries if the Eligible Individual has signed a subrogation and reimbursement agreement and has been denied worker's compensation benefits. Contact the Fund Office if you have questions about coverage for occupational Injuries or Illnesses.

Any amounts paid are subject to the Plan's limitations and exclusions. Additionally, the coinsurance amounts apply after the Eligible Individual pays any applicable copayment and deductible unless otherwise noted.

Hospital and Urgent Care Services	**In-Network**	**Out-of-Network**
Hospital and Urgent Care Clinic Services and Supplies (including Physician Visits and Facility Charges)	Payable at 85% of Covered Expenses	Payable at 75% of Covered Expenses*

Please see the "No Surprises Act" topic at the end of this "Medical Coverage" section for important information regarding coverage of certain out-of-network items and services as in-network items and services effective May 1, 2022.

- Daily Room and Board charges if semi-private or ward accommodations are used, general duty nursing care (excluding professional services of Physicians, private duty nurses or charges to intensive nursing care). If a private room is used, the Plan will pay only the Hospital's most common Room and Board charge, for a semi-private room.

- Transportation Services

  - Ground-based transportation and/or ambulance services will be provided only to the nearest health care facility qualified to provide the Medically Necessary services for the Emergency, acute Illness, or provider-initiated inter-health care facility transfer.

  - Air Ambulance Services and sea-based transportation and/or ambulance services will be provided only as Medically Necessary (i) due to inaccessibility by ground transport and/or (ii) if the use of ground transport would result in a serious adverse

impact on the Eligible Individual's health status.

- Expenses incurred for any transportation and/or ambulance services to transport an Eligible Individual will be covered only if Medically Necessary to treat an Emergency or an acute Illness, and then only to the nearest facility qualified to provide the Medically Necessary treatment of an Emergency or acute Illness or provider-initiated inter-health care facility transfer.

- Expenses incurred for transportation and/or ambulance services are not covered if such services are incurred for the convenience of the Eligible Individual, the Eligible Individual's health care provider, or the Eligible Individual's family or other individual involved in the Eligible Individual's care. Expenses for any transportation and/or ambulance services are not covered if the Plan determines the transportation and/or ambulance services are not Medically Necessary.

Please see the "No Surprises Act" topic at the end of this "Medical Coverage" section for important information regarding coverage of out-of-network Air Ambulance Services as in-network Air Ambulance Services effective May 1, 2022.

♦ Diagnostic X-Rays and Lab*

- Limitations-Diagnostic X-ray and Laboratory Examination Benefits are not provided for:

  ► Any such procedure not recommended and approved by a Physician; or

  ► Dental care and Oral Surgery (except when rendered in connection with a bodily Injury).

♦ Inpatient surgical expenses*

♦ Outpatient surgical expenses*

♦ Other Hospital services and supplies which are Medically Necessary and required for treatment,* excluding: (1) Room and Board Charges, (2) professional services of Physicians; (3) private duty nursing; and (4) Hospital facility charges for Physician office visits at facilities (a) owned, leased, or licensed by; (b) part of a Hospital network or on a Hospital campus; or (c) otherwise affiliated with a Hospital, if such office visit would not reasonably be considered a Hospital visit but for such office or Physician's relationship with a Hospital or Hospital network.

Please see the "No Surprises Act" topic at the end of this "Medical Coverage" section for important information regarding coverage of certain out-of-network items and services as in-network items and services effective May 1, 2022.

Hospital Benefits (Sickness and Injury)	**In-Network**	**Out-of-Network**
♦ Room and Board	85% Covered Expense	75% of Semi-Private Rate*
♦ ICU Room and Board		75% of ICU rate*
Please see the "No Surprises Act" topic at the end of this "Medical Coverage" section for important information regarding coverage of certain out-of-network items and services as in-network items and services effective May 1, 2022.		
♦ Nursing Services ♦ Pathology ♦ Surgical Procedures ♦ Anesthesia ♦ Ambulance ♦ Treatment or Service in an Ambulatory Surgical Facility ♦ Blood and Blood Plasma	85% of Covered Expenses	75% of Covered Expenses*
Please see the "No Surprises Act" topic at the end of this "Medical Coverage" section for important information regarding coverage of certain out-of-network items and services as in-network items and services effective May 1, 2022.		

Long-term inpatient care during an extended Period of Crisis is covered under "Hospital Benefits" but only if the services are provided by state-certified medical professionals. Long-term inpatient care must be preauthorized by the Fund Office and is limited to care at a licensed facility meeting generally accepted industry standards of care that is within a 50-mile radius of the Eligible Individual's home and can provide the level of care that is Medically Necessary at the lowest cost (unless such a facility is not available within a 50-mile radius of the Eligible Individual's home, in which case during preauthorization, the Fund Office may approve a facility outside of those geographic limitations).

Hospital benefits are not provided for:

- ♦ Charges for special nursing, Physicians, Dentists, or other specialists.
- ♦ Charges incurred in connection with treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or alveolar process, or Oral Surgery, except as specifically provided.

Durable Medical Equipment	**In-Network**	**Out-of-Network**
♦ Durable Medical Equipment such as Oxygen, Pacemakers, Artificial Limbs or Casts,	85% of Covered Expenses	75% of Covered Expenses*

Splints, Braces, Wheelchairs, Canes, Augmentative Communication Devices, and CPAP equipment (see pages 29 and 30 for more detailed information about CPAP supplies)		

**If you purchase Durable Medical Equipment on your own from an Out-of-Network Provider, the Plan will reimburse you at the In-Network rate if:*

- *You provide purchase documentation satisfactory to the Plan, including an itemized receipt, to the Plan Administrator, evidencing the amount you paid for the Durable Medical Equipment;*
- *The Plan confirms with UMR that the amount you paid for the Durable Medical Equipment is the same as or less than In-Network rates.*

The Plan reserves the right not to pay for charges related to the replacement or repair of durable medical equipment which the Plan determines is damaged or destroyed due to carelessness, negligence or reasons other than normal wear and tear.

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

****Please see the "No Surprises Act" topic at the end of this "Medical Coverage" section for important information regarding coverage of certain out-of-network items and services as in-network items and services effective May 1, 2022.***

- 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.
- ***Note:*** *Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any 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

Please see the "No Surprises Act" topic at the end of this "Medical Coverage" section for important information regarding coverage of certain out-of-network items and services as in-network items and services effective May 1, 2022.		
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 or Out-of-Network providers are used.
- *Certain* surgical procedures may be required to be performed on an outpatient basis. Contact UMR at the number on the back of your ID card 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 Covered Expenses, provided the procedure is preauthorized and determined to be Medically Necessary, consistent with relevant United Healthcare medical policy guidelines.

	In-Network	**Out-of-Network**
Telehealth-Only Visits	100% of Covered Expenses	75% of Covered Expenses and subject to deductible and coinsurance

- Effective March 19, 2020 through March 31, 2020, in-network telehealth services received through Doctor on Demand will be covered at 100% (no member cost share). Out-of-network telehealth services for this period will be covered and subject to out-of-network office visit cost sharing (deductible and coinsurance).
- Effective April 1, 2020, telemedicine services received through Teladoc will be covered at 100% (no member cost share). Out-of-network telehealth services received on or after April 1, 2020 will be covered and subject to out-of-network office visit cost sharing (deductible and coinsurance).

	In-Network	**Out-of-Network**
Physician Telehealth Visits	100% of Covered Expenses through 12/31/2022. As of 1/1/2023, 85% of Covered Expenses	75% of Covered Expenses and subject to deductible and coinsurance

- Effective April 1, 2020, through December 31, 2022, in-network Physician telehealth visits will be covered at 100% (no member cost share). Out-of-network Physician telehealth visits will be covered and subject to out-of-network office visit cost sharing (deductible and coinsurance). In-network Physician telehealth visits provided on or after January 1, 2023, will be covered and subject to standard cost-sharing.

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

Unless administered or provided by a healthcare provider in the course of a visit, prescription drugs will not be covered by the Plan unless they are purchased at a Sav-Rx In-Network pharmacy or through the Sav-Rx Mail Order Pharmacy. Beginning April 1, 2020, non-network pharmacies include Walmart and Sam's Club. For inquiries about In-Network and Out-of-Network pharmacies, visit https://www.savrx.com or call (866) 233-IBEW (4239).

Please Note: The Plan will cover up to a 90-day maximum supply of a prescription drug in one fill, subject to the Pharmacy's ability to fill a 90-day supply. The cost-sharing minimum and maximum rules below apply to each prescription drug order filled, regardless of the quantity. A 90-day supply is covered at a discounted rate, however, that is priced as if you were filling two separate 30-day supplies, rather than three separate 30-day supplies.

Retail:	
Brand Name	$9.00 minimum co-pay or 20% of the cost over $9.00 up to a maximum of $50.00 total (this cost-sharing maximum applies to any prescription fill regardless of the quantity, which may be up to a 90-day maximum supply subject to the Pharmacy's ability to fill a 90-day supply).
Generic	$5.00 minimum co-pay or 20% of the cost over $5.00 up to a maximum of $25.00 total (this cost-sharing maximum applies to any prescription fill regardless of the quantity, which may be up to a 90-day maximum supply subject to the Pharmacy's ability to fill a 90-day 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 (this cost-sharing maximum applies to any prescription fill regardless of the quantity, which may be up to a 90-day maximum supply subject to the

	Pharmacy's ability to fill a 90-day supply).
Generic	$10.00 minimum co-pay or 10% of the cost over $10.00 up to a maximum of $50.00 (this cost-sharing maximum applies to any prescription fill regardless of the quantity, which may be up to a 90-day maximum supply subject to the Pharmacy's ability to fill a 90-day supply).
Prescription Drugs: *To obtain a current list of prescriptions requiring prior authorization or step therapy, please contact the Fund Office.*	Certain drugs will be subject to a prior authorization and some will also be subject to "Step Therapy", split fills (i.e. a 30-day prescription will be filled in two 15-day increments to determine whether the drug is tolerated by participant to reduce waste) and quantity level limits (dispensing only quantities that will actually be used). The Step Therapy program is a "step" approach to providing the medications that treat your condition. This means that you may first need to try a more clinically appropriate or cost-effective medication before certain higher-cost medications will be approved. Step Therapy programs can help both you and the Plan save money. A medication meets the Plan's Step Therapy requirements if it is the most cost-effective medication available to treat a disease or condition. This means that if your doctor prescribes you a new medication that is subject to the Plan's Step Therapy program, the Plan will initially only cover the least expensive "step" in that drug class, typically a generic drug. If the first step medication does not safely and effectively treat your condition, the Plan will cover the next "step", typically a formulary brand medication. If your doctor recommends prescription drugs or quantities that do not comply with the prior authorization and/or Step Therapy protocols, your doctor will need to submit a prior authorization (PA) request that will include the medical reasons supporting that request to Sav-Rx. Your doctor can contact Sav-Rx Prescription Services to obtain prior authorization forms.
Pharmacy Specialty Prescriptions Program: *Certain specialty drugs may be available at a discounted price through Sav-Rx's specialty drug program. Specialty drugs require preauthorization and are limited to 30 days' supply, except as noted below for individuals who already were*	**Specialty Drug Program** – Eligible Individuals who are prescribed drugs listed on Sav-Rx's Specialty Drug list will participate in Sav-Rx's Specialty Drug Program. After the initial fill of a specialty drug prescription, specialty drugs must then be purchased through Sav-Rx's Specialty Pharmacy. Sav-Rx also helps Eligible Individuals obtain manufacturer copayment coupons or other financial assistance to reduce copayment amounts for certain specialty drugs purchased through the Sav-Rx Specialty Pharmacy. An Eligible Individual's net copayment for a specialty drug subject to Sav-Rx's specialty drug program and purchased through Sav-Rx's Specialty Pharmacy (based upon the Eligible Individual's out-of-pocket

receiving 90-day supplies of certain prescription drugs prior to April 1, 2020. For more information and a list of specialty drugs subject to these requirements, contact Sav-Rx at 866-233-IBEW (4239). *To obtain a current list of the drugs on Sav-Rx's specialty drug list, please contact the Fund Office.*	cost for copayments) will not be greater than the specialty drug copayment amount would have been if the Sav-Rx Specialty Drug Program were not in place. Any coupon, rebate, and/or other financial assistance applied directly towards an Eligible Individual's copayment at the time of purchase under Sav-Rx's Specialty Drug Program will not be applied towards satisfying such Eligible Individual's maximum copayment or annual out-of-pocket costs. —The copayment for a specialty drug is as follows: Retail Brand Name Drugs - $9.00 minimum co-pay or 20% of the cost over $9.00 up to a maximum of $50.00 total (this cost-sharing maximum applies to any prescription fill regardless of the quantity, which, if eligible as described below, may be up to a 90-day maximum supply subject to the Pharmacy's ability to fill a 90-day supply). Retail Generic Drugs - $5.00 minimum co-pay or 20% of the cost over $5.00 up to a maximum of $25.00 total (this cost-sharing maximum applies to any prescription fill regardless of the quantity, which, if eligible as described below, may be up to a 90-day maximum supply subject to the Pharmacy's ability to fill a 90-day supply). Mail Order Brand Name Drugs - $18.00 minimum co-pay or 20% of the cost over $18.00 up to a maximum of $100.00 total (this cost-sharing maximum applies to any prescription fill regardless of the quantity, which, if eligible as described below, may be up to a 90-day maximum supply subject to the Pharmacy's ability to fill a 90-day supply). Mail Order Generic Drugs - $10.00 minimum co-pay or 20% of the cost over $10.00 up to a maximum of $50.00 total (this cost-sharing maximum applies to any prescription fill regardless of the quantity, which, if eligible as described below, may be up to a 90-day maximum supply subject to the Pharmacy's ability to fill a 90-day supply). An Eligible Individual who is receiving specialty drugs that cost less than $5,000 per 90-day supply is eligible for a 90-day fill of the specialty drug as long as the Eligible Individual was receiving 90-day fills for the specialty drug from the Plan prior to April 1, 2020. Please note the special pricing information regarding 90-day fills above under the heading "Prescription Drug Benefit."
Compound Drug Control Program:	Compound drugs, both prescription and nonprescription, are not a covered benefit under the Plan.
"Off-Label" Prescription	"Off-Label" drug use is a prescription by a Provider, acting within

Drug Coverage:	the scope of the Provider's licensure, for a U.S. Food and Drug Administration (FDA) approved drug for treatment or a patient population that is not included in the FDA approved labeling. Prescription drugs prescribed for an Off-Label use are not covered under the Plan.
NOTE: Diabetic supplies such as glucose monitors, insulin, insulin hypodermic needles and syringes which can be purchased either directly and reimbursed by the Plan, or through the prescription drug program are subject to the prescription drug benefit limitations.	

Other Covered Expenses	**In-Network**	**Out-of-Network**
The following is a partial list of frequently-utilized services and supplies.		
♦ Supplies ♦ Physical Therapy ♦ Breast prosthesis and reconstruction surgery after breast cancer including breast reconstruction surgery and reconstruction of other breast for symmetrical appearance and treatment of physical complications of all stages of mastectomy ♦ Mastectomy/Prosthetics Bras and Inserts (4 bras/year and 1 prosthesis per side per 2 years) ♦ Breastfeeding support, supplies and counseling ♦ CPAP equipment as follows:	85% of Covered Expenses	75% of Covered Expenses

Equipment	**Replacement Interval**
CPAP (Single Pressure Device)	1 per 5 years
Auto CPAP (Adjusting Pressure)	1 per 5 years
BiLevel S (Bi-Level Pressure	1 per 5 years
Auto Bi-Level (Adjusting Bi-Level Pressure)	1 per 5 years
Full Face Mask	1 per 3 months
Full Face Mask Cushion Replacement	1 per month

Nasal Mask	1 per 3 months		
Nasal Pillow Replacements	2 per month		
Combination Oral/Nasal Mask	1 per 3 months		
Oral Interface	1 per 3 months		

Other Covered Expenses		**In-Network**	**Out-of-Network**
The following is a partial list of frequently-utilized services and supplies.			
Equipment	**Replacement Interval**		
Headgear	1 per 6 months		
Chinstrap	1 per 6 months		
CPAP Tubing	1 per 3 months		
Climateline Tubing for ResMed S9	1 per 3 months		
Disposable Filter	3 per month		
Non-Disposable Filter	1 per 6 months		
Comfort Care Pad (used to reduce redness on the face where mask contacts skin)	1 per month		
Heated Humidifier	1 per 3 years		
Replacement Humidifier Chamber	1 per 6 months		

Other Covered Expenses	**In-Network**	**Out-of-Network**
The following is a partial list of frequently-utilized services and supplies.		
♦ Temporomandibular joint ("TMJ") and craniomandibular syndrome ("CMS") (but not for braces and orthodontic)	85% of Covered Expenses	75% of Covered Expenses
♦ Dietary and Nutritional Counseling	85% of Covered Expenses	75% of Covered Expenses
♦ Charges for services relating to dietary counseling upon release from the Hospital are covered as long as: • The charges are a single expense or related to a single episode of care,		

- The services are provided by a registered dietitian as an integral part of a treatment plan for chronic disease management (for example, coronary, diabetic, digestive or circulatory disease cases),

- The services are not solely for the treatment of an overweight condition or a condition of obesity or morbid obesity, and

♦ The charges are billed by a Hospital or a Physician in a clinical setting.

Behavioral Counseling and Education to Promote a Healthy Lifestyle	85% of Covered Expenses	75% of Covered Expenses
	In-Network	**Out-of-Network**
Dietary and Nutritional Counseling – Eating Disorders and Substance Abuse Disorders	85% of Covered Expenses	75% of Covered Expenses
Weight Loss Program	85% of Covered Expenses	75% of Covered Expenses

♦ Charges for services and treatment recommended by a Physician of Medicine (M.D.) as part of a weight loss program for an individual whose Body Mass Index is at least 30. The following services are covered subject to the weight loss program maximums. As well as the provision of supporting documentation in your medical record from your M.D.:

- Physician office visits;

- Prescription medications;

- Nutritional counseling;

- Medically supervised programs such as Optifast® or Medifast®; and,

- Weight Watchers®, L.A. Weight Loss® or other similar weight loss programs subject to the provision of the following documentation:

- Physician's prescription;

- Receipts showing amounts paid and dates of attendance; and,

- Physician monitoring of participation in the program twice yearly, as documented in medical records.

However, coverage is not provided for:

- Self-help books or tapes;

- Hypnosis;

- Cook books; and,
- Special foods.

♦ **Maximum Benefit Limits.** $1,500 during a single 2 consecutive-calendar-year-period within any 10-consecutive-calendar-year period (Amounts paid by the Plan for prescription drugs prescribed as part of the weight loss program will be among the amounts counted against this limit.)

	In-Network	**Out-Of-Network**
Custom Molded Orthopedic Shoes, but only one pair per Calendar Year as approved	85% of Covered Expenses	75% of Covered Expenses
Custom Molded Orthotic Appliances* (only 2 pair/Calendar Year) The third 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
Jobst 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	$3,000 per one pregnancy or per one pregnancy attempt per calendar year, 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. Coverage applies only if the Eligible Member has received a diagnosis from a Physician of an underlying cause of infertility.	
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, Counseling and Evaluation (including Amniocentesis, BCRA Testing, and BCRA Lab Screening)	One genetic test 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, and prenatal exams. These services must be Medically Necessary and preventative according to the Advisory Committee on Immunizations Practices or the Health and Resources Administration. 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
Men and Women	100% of Covered Expenses for one health maintenance mammogram per Calendar Year	
Routine Colonoscopy, Colorectal Cancer Screening, and CT Colonography	85% of Covered Expenses	75% of Covered Expenses

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. If an audiologist determines that a hearing aid device that consists of two or more components (at least one of which is placed on or in one ear and at least one of which is placed on or in the other ear) is Medically Necessary for the improvement of hearing of one or both ears, the Plan will cover such a multi-component hearing aid device, subject to the $1,500 per ear limit, regardless of whether the multi-ear, multi-component hearing aid device is primarily or solely Medically Necessary for the improvement of hearing in one ear or both.		
	In-Network	**Out-of-Network**
Cochlear Implants	85% of Covered Expenses	75% of Covered Expenses
Cochlear Implant Processor Replacements	Replacement processors for cochlear implants are covered as long as the affected Eligible Individual trades in their old implant processor.	
Chiropractic and Acupuncture	$500 combined per Calendar Year	
	In-Network	**Out-of-Network**
	85% of Covered Expenses	75% of Covered Expenses
Any medical expense benefit payments made on behalf of an Eligible Individual at any time during a Calendar Year under this Plan or any previous medical plans of the Fund for all chiropractic and acupuncture care will be used in determining the individual's remaining Chiropractic and Acupuncture Care Calendar Year Maximum Benefit.		
	In-Network	**Out-of-Network**
COVID-19 Diagnostic Testing and Related Visit	**With an order or individualized clinical assessment from a health care provider:** 100% of Covered Expenses	**With an order or individualized clinical assessment from a health care provider:** 100% of Covered Expenses
	Over-the-counter tests for personal use for diagnostic purposes (without an order or individualized clinical	**Over-the-counter tests for personal use for diagnostic purposes (without an order or individualized clinical**

	assessment from a health care provider): 100% of Covered Expenses (effective January 15, 2022)	**assessment from a health care provider):** The lesser of $12 or the cost of the test (effective January 15, 2022)
The Plan will cover 100% (at no member cost) in vitro diagnostic products for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 that are approved, cleared, or authorized under the Federal Food, Drug, and Cosmetic Act, and the administration of such in vitro diagnostic products. Also covered at 100% (no member cost share) are items and services furnished to Eligible Individuals during health care provider office visits (including both in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic product as described above, to the extent such items and services relate to the furnishing or administration of such product or to an Eligible Individual's evaluation for purposes of determining his or her need for the product.		
Effective January 15, 2022 and for the duration of the public health emergency related to COVID-19, the Plan will cover up to eight over-the-counter COVID-19 tests per Eligible Individual per calendar month in accordance with federal guidelines. Subject to the above limits, the Plan will directly cover over-the-counter COVID-19 tests when obtained from an in-network Pharmacy or from Sav-Rx's direct-to-consumer shipping program. "Directly cover" means that an Eligible Individual does not need to pay out-of-pocket for the test and seek reimbursement if Plan enrollment identification is provided to the seller. Also subject to the above limits, the Plan will cover over-the-counter COVID-19 tests when obtained from an out-of-network Pharmacy or any other seller or retailer by reimbursing the Eligible Individual for the lesser of the cost of the test or $12. The Eligible Individual must submit the receipt for the test to Sav-Rx to obtain reimbursement.		

	In-Network	**Out-of-Network**
Organ and Bone Marrow Transplant Surgery	85% of Covered Expenses	75% of Covered Expenses*
Please see the "No Surprises Act" topic at the end of this "Medical Coverage" section for important information regarding coverage of certain out-of-network items and services as in-network items and services effective May 1, 2022.		
The Plan covers an Eligible Individual's expenses for services, supplies, drugs and related aftercare for certain human organ and tissue transplant, bone marrow transplant and stem cell support procedures which are Medically Necessary, which are payable under other provisions of the Plan, and which meet the special requirements for transplant procedures listed below. Charges incurred for kidney and cornea transplants are covered on the same basis as any other Covered Expense and are not subject to the special requirements for transplant procedures. The following procedures are approved for coverage subject to the special requirements for transplant procedures: ♦ Kidney (from a live donor); ♦ Heart;		

- Heart-lung;
- Liver;
- Lung (single or double);
- Pancreas transplant for:
  - A diabetic with end-stage renal disease (ESRD) who has received a kidney transplant or will receive a kidney transplant during the same operative session; or
  - A medically uncontrollable, labile (unstable) diabetic with one or more secondary complications, but whose kidneys are not seriously impaired.
- Bone marrow transplant and stem cell support procedures as follows:
  - Allogeneic or syngeneic bone marrow for:
    - ► Acute leukemia;
    - ► Chronic myelogenous leukemia;
    - ► Multiple myeloma;
    - ► Myelodysplasia;
    - ► Aplastic anemia;
    - ► Wiskott-Aldrich syndrome;
    - ► Cartilage-hair hypoplasia;
    - ► Kostmann's syndrome;
    - ► Infantile osteopetrosis;
    - ► Primary granulocyte dysfunction syndrome;
    - ► Neuroblastoma;
    - ► Thalassemia major;
    - ► Chronic granulomatous disease;
    - ► Severe mucopolysaccharidosis;
    - ► Burkitt’s lymphoma;
    - ► Hodgkin’s and non-Hodgkin’s lymphoma;

- ► Severe combined immunodeficiency disease;
- ► Mucolipidosis;
- ► Adrenoleukodystrophy (ALD); and
- ► Myelodysplastic syndrome.

- Autologous bone marrow and autologous peripheral stem cell support for:
  - ► Acute lymphocytic or non-lymphocytic leukemia,
  - ► Advanced Hodgkin's lymphoma,
  - ► Advanced non-Hodgkin's lymphoma,
  - ► Advanced neuroblastoma,
  - ► Breast Cancer
  - ► Chronic myelogenous leukemia, and
  - ► Testicular, mediastinal, retroperitoneal and ovarian germ cell tumors for the treatment of breast cancer.

The Plan does not cover services such as chemotherapy, radiation therapy (or any therapy that damages the bone marrow), supplies, drugs and aftercare for or related to bone marrow transplant, stem cell support or peripheral stem cell support procedures for a condition not specifically listed above as covered. Conditions specifically excluded from coverage in connection with the preceding sentence include, but are not limited to:

- ► Malignant melanoma and other skin cancers,
- ► Lung cancer,
- ► Prostate cancer,
- ► Brain tumors,
- ► Uterine and cervical cancer,
- ► Epithelial cell tumors of the ovary,
- ► Colon cancer, and
- ► Other gastrointestinal tract cancers (including the pancreas).

Special Requirements for Transplant Procedures

The following special requirements apply to coverage for transplant procedures.

Effective May 4, 2021, there will be no exclusions for kidney, skin, and cornea transplants:

► Before the procedure is scheduled, you must ask the Plan Administrator for a list of Plan-approved transplant centers.

► Transplant procedures are subject to case management by the Plan or a case manager designated by the Plan. Before the procedure is scheduled, United Healthcare will identify the Plan's case manager assigned to the transplant procedure.

► Directly Related organ and tissue acquisition costs are covered. This includes surgical, storage, and transportation costs, but does not include expenses incurred by or on behalf of the donor, including but not limited to medical expenses, incurred and related to the acquisition of an organ or tissue used in a covered transplant procedure, except as follow:

- If the transplant recipient is an Eligible Individual, Medically Necessary expenses of the donor directly related to the organ or tissue acquisition will be eligible for payment by the Plan, subject to the Plan's standard cost-sharing provisions, but only to the extent such Medically Necessary expenses (a) are not covered by any other plan of benefits, and (b) would otherwise constitute an eligible Expense if incurred by an Eligible Individual.

- If the transplant donor is an Eligible Individual, but the recipient is not, Medically Necessary Eligible Expenses related directly to organ or tissue acquisition will be eligible for payment under the Plan subject to the Plan's cost-sharing provisions, but only to the extent such Medically Necessary costs are not payable under any other plan of benefits.

The above provisions will be effective as of May 4, 2021.

♦ Effective May 4, 2021, the Plan will not provide any disability benefits to or on behalf of a donor who is not an Eligible Individual.

♦ 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 must:

- Identify the medical condition for which the transplant procedure is requested,

- 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

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

♦ The Plan may require, as a condition of authorization, review of the proposed transplant procedure and of the recipient's medical condition by a Physician designated by the Plan.

Excluded expenses (i.e., not Covered Expenses) include:

- Services or supplies not reimbursed under other provisions of this Plan;
- Services unrelated to the covered transplant procedure or unrelated to the diagnosis or treatment of an Illness resulting directly from such transplant;
- Transplant-related services performed in a non-approved transplant center;
- 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 coverage;
- Effective May 4, 2021, transplantation or implantation of an Experimental non-human organ or tissue;
- Use of a left ventricular-assist device or any similar equipment as part of clinical trials for research or for a period in excess of thirty (30) days, consecutive or not, per covered transplant procedure;
- Effective May 4, 2021, cardiac rehabilitation services when not provided to the Eligible Individual transplant recipient immediately following discharge from the Hospital after transplant surgery;
- Air Ambulance Transportation, except with respect to the transportation of the organ to the location of the surgery where 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;
- Effective May 4, 2021, living donor transplants of the liver, lung or any other organ (except bone marrow), such as selective islet cell transplants of the pancreas;
- Re-transplant of organ or bone marrow during the 365-day period following the transplant procedure; and
- Any exclusions listed in the General Exclusion section.

	In-Network	**Out-of-Network**
Hospice Care	85% of Covered Expenses	75% of Covered Expenses

Contact the Fund Office with questions about covered Hospice care services and benefit levels. Before seeking Hospice care for any Eligible Individual, contact UMR Care Management at the phone number on the back of your ID card.

The Plan provides a Hospice care program for terminally-ill Eligible Individuals. The Plan pays for Covered Expenses through in-network providers and out-of-network providers in the percentage specified above. The Hospice care program pays for the following Covered Expenses:

- Nursing care by an R.N. or L.P.N. and services of home health aides (such services may be furnished on a 24-hour basis during a Period of Crisis or if the care is necessary to maintain the Eligible Individual at home);

- Medical social services, counseling services or psychological therapy by a social worker or a psychologist;

- Physical and occupational therapy and speech language pathology;

- Non-prescription drugs used for Palliative Care, medical supplies, bandages and equipment, drugs and biologicals used for pain and symptom control; and

- Skilled Nursing Facility short-term inpatient care to provide Respite Care, Palliative Care or care in Periods of Crisis.

- Respite Care is limited to Eligible Individuals actively participating in the Plan's Hospice care program. Respite Care is limited to no more than eight hours per week.

Note: Covered services do *not* include custodial care. Patient must be homebound to be eligible.

Eligibility for the Hospice Care Program

To be eligible for this Hospice care program, a Physician must certify that an Eligible Individual's condition is terminal. Terminal is defined as having six (6) months or less to live. 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 two days after the Eligible Individual begins receiving Hospice care.

There are special Covered Expenses for Hospice care that are not covered under the Plan's regular medical benefits. For that reason, an Eligible Individual must elect to use the Hospice care program for most of his or her care related to the terminal condition instead of receiving benefits under the regular Covered Medical Expense benefit. To apply for the Hospice care program and to have Hospice care preauthorized, contact UMR Care Management at the phone number on the back of your ID card and follow the instructions they provide. Precertification must be completed before any Hospice care is given to the Eligible Individual. Once an Eligible Individual's condition is certified as terminal, the Eligible Individual can use the Hospice care program receiving all Palliative Care and most direct care of the terminal condition under the Hospice care program.

An Eligible Individual can decide to cancel benefits under the Hospice care program at any time.

However, once this decision is made, the right to Hospice care benefits is permanently waived and that Eligible Individual cannot at any future time be Covered under the Hospice care program. At that point, benefits related to a terminal condition will be provided for regular Covered Medical Expenses.

Other Medical Benefits When Terminally Ill

If the terminally-ill Eligible Individual requires surgery or hospitalization due to the terminal

condition, such expenses would be paid under the regular Covered Medical Expenses of the Plan. Expenses for treatment of any Injury or Sickness unrelated to the person's terminal condition also will be paid under the regular Covered Medical Expenses of the Plan.

Exclusions and Limitations of Hospice Care Program

Charges for the following services and supplies are *not* covered under the Hospice care program:

- Any services or supplies not provided as "core services" by the Hospice;
- Bereavement counseling (counseling services provided to a terminal person's family after death);
- Administrative services;
- Childcare or housekeeping services;
- Transportation, except in Emergency situations;
- Long-term inpatient care (these charges are payable under the regular Covered Medical Expenses of the Plan);
- Surgical operations or hospitalizations due to medical complications of the terminal condition (these charges are payable under the regular Covered Medical Expenses of the Plan); or
- Any services or supplies provided for treatment of any Injury or Sickness other than the terminal condition (these charges are payable under the regular Covered Medical Expenses of the Plan).

	In-Network	**Out-of-Network**
Home Health Care	85% of Covered Expenses	75% of Covered Expenses

An Eligible Individual should contact the Fund Office before arranging for home health care. Contact the Fund Office if you have questions about covered services or benefit levels.

Note: Covered services do *not* include custodial care. Patient must be homebound to be eligible.

If an Eligible Individual needs private home health care, the Plan will pay for in-network and out-of-network services in the percentages specified in the Schedule of Benefits for the following Covered Expenses:

- Rehabilitative Skilled Care prescribed by a Physician and provided by or through Home Health Agency employees, including, but not limited to:
  - Registered nurse;

- Licensed registered physical therapist;
- Master's level clinical social worker;
- Registered occupational therapist;
- Certified speech and language pathologist;
- Medical technologist; or
- Registered dietician.

♦ Services of a home health aide or social worker employed by the Home Health Agency when provided in conjunction with services provided by Home Health Agency employees;

♦ Use of appliances that are owned or rented by the Home Health Agency; and

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

The following services, even when provided to a patient at home, for an Eligible Individual who participates in the Home Health Care program will be billed and covered as outpatient services:

♦ Physical therapy;

♦ Occupational therapy; and

♦ Speech therapy.

No payment will be made for child care or housekeeping services. Covered services must be rehabilitative and do not include custodial care. No payment will be made for charges that do not meet the requirements for the home health care program, are not indicated as Covered Expenses above, or are in excess of any specified maximum benefit or other relevant limitation under the Plan.

	In-Network	**Out-of-Network**
Skilled Nursing Facility Care	85% of Covered Expenses 30 Day Maximum per Calendar Year	75% of Covered Expenses 30 Day Maximum per Calendar Year

Before arranging for a Skilled Nursing Facility confinement for any Eligible Individual, contact UMR Care Management to find out if it is an approved confinement. Contact the Fund Office if you have questions about covered services or benefit levels.

The Physician of the Eligible Individual may recommend a Skilled Nursing Facility if any Eligible Individual needs nursing care after hospitalization. A Skilled Nursing Facility is designed to provide the proper nursing care to a person who is well enough to leave the Hospital but is not yet well enough to go home.

Once the deductible has been satisfied, the Plan pays Covered Expenses for in-network and out-of-network services in the percentages specified above. Covered Expenses are limited to the number days of confinement per Calendar Year specified above.

Covered Expenses include Room and Board Charges and Medically Necessary services and supplies provided to the Eligible Individual in an approved Skilled Nursing Facility.

Note: Covered services do *not* include custodial care.

To ensure payment under the Plan, these requirements must be met:

- A Physician must certify that the Skilled Nursing Facility confinement and nursing care are Medically Necessary for the patient's recovery from an Injury or Sickness;
- The confinement must be preceded by at least three consecutive days of hospitalization for which Plan benefits are payable;
- The confinement must start within 30 days after hospitalization for which Plan benefits are payable or within 30 days after termination of confinement in a Skilled Nursing Facility for which Plan benefits are payable;
- The Eligible Individual must not remain in the Skilled Nursing Facility for more than 30 days per Calendar Year;
- The Skilled Nursing Facility confinement must be directly related to the condition which required the previous hospitalization; and
- The confinement must be provided in a facility which meets the definition of a Skilled Nursing Facility.

Mental Health Conditions and Chemical Dependency

The outpatient and inpatient mental health/chemical dependency benefits are subject to, and apply toward the medical deductibles specified above. Any out-of-pocket expenses an Eligible Individual must pay for mental health deductibles and coinsurance count toward the Plan's out-of-pocket maximum limits.

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addition Equity Act and ERISA Section 712.

T.E.A.M. Employee Assistance Program performs chemical dependency and mental health services case management coordination.

Inpatient Care:	**In-Network**	**Out-of-Network**
Room and Board	85% of Covered Expenses	75% of Covered Expenses*
Hospital Additionals (other than consultation and group therapy)	85% of Covered Expenses	75% of Covered Expenses*
Diagnosed Consultation and Group Therapy	85% of Covered Expenses	75% of Covered Expenses*
Medication Management	85% of Covered Expenses (Deductible Does Not Apply)	75% of Covered Expenses*
Partial Hospitalization	85% of Covered Expenses	75% of Covered Expenses*

Consultation and Individual Therapy	85% of Covered Expenses	75% of Covered Expenses*
Please see the "No Surprises Act" topic at the end of this "Medical Coverage" section for important information regarding coverage of certain out-of-network items and services as in-network items and services effective May 1, 2022.		
Diagnostic Evaluation	85% of Covered Expenses (Deductible Does Not Apply)	75% of Covered Expenses*
Please see the "No Surprises Act" topic at the end of this "Medical Coverage" section for important information regarding coverage of certain out-of-network items and services as in-network items and services effective May 1, 2022.		
Diagnosed Consultation and Group Therapy	85% of Covered Expenses	75% of Covered Expenses*
Behavioral Disorders such as attention Deficit Disorder and Attention Deficit Hyperactivity Disorder	85% of Covered Expenses	75% of Covered Expenses*
Marital Counseling, Family Counseling, and Behavioral Family Therapy	85% of Covered Expenses	75% of Covered Expenses*
Medication Management	85% of Covered Expenses (Deductible Does Not Apply)	75% of Covered Expenses*
Intensive Outpatient Day Treatment	85% of Covered Expenses	75% of Covered Expenses*
Please see the "No Surprises Act" topic at the end of this "Medical Coverage" section for important information regarding coverage of certain out-of-network items and services as in-network items and services effective May 1, 2022.		
Chemical Dependency		
Inpatient Care:	**In-Network**	**Out-of-Network**
Room and Board	85% of Covered Expenses	75% of Covered Expenses*
Hospital Additionals (other than consultation and group therapy)	85% of Covered Expenses	75% of Covered Expenses*
Diagnosed Consultation and Group Therapy	85% of Covered Expenses	75% of Covered Expenses*
Medication Management	85% of Covered Expenses (Deductible Does Not Apply)	75% of Covered Expenses*
Other Than Diagnosed Consultation and Group Therapy	85% of Covered Expenses	75% of Covered Expenses*
Please see the "No Surprises Act" topic at the end of this "Medical Coverage" section for important information regarding coverage of certain out-of-network items and services as in-network items and services effective May 1, 2022.		
Outpatient Care:	**In-Network**	**Out-of-Network**

Consultation and Individual Therapy, including ABA Therapy	85% of Covered Expenses	75% of Covered Expenses
Diagnostic Evaluation	85% of Covered Expenses (Deductible Does Not Apply)	75% of Covered Expenses
Medication Management	85% of Covered Expenses (Deductible Does Not Apply)	75% of Covered Expenses

Mental Health Benefits Procedures

Type of Service	Procedure
Outpatient Mental Health or Chemical Dependency	The Eligible Individual's provider submits the claim and the claim is paid at the highest level of benefits.
Inpatient Mental Health	**In-network** United Healthcare providers will notify Optum of any required admissions. Out-of-network providers must also notify Optum of any required admissions and certify that treatment is Medically Necessary. However, if the treating Physician will not contact Optum, the Eligible Individual must contact Optum. Optum will send a copy of the certification or notice to the Fund Office. Optum will then take the lead role in co-managing the case. The provider submits the claim for the Eligible Individual, and the claim is paid at the highest level of benefits.

Treatment of Mental Health Conditions

Covered Expenses for in-patient confinements include charges for treatment by a Doctor of Medicine, Clinical or Child Psychologist holding a Ph.D. or Psy.D., Clinical or Child Psychologist holding an M.A. or M.S.W. whose work is supervised by either an M.D. or Ph.D. or Psy.D.; or a Licensed Therapist holding an M.A. or M.S.W. or similarly qualified professional working in their area of training as determined to be medically appropriate. You may contact Optum for additional information with regard to whether a professional's services are medically appropriate.

Please see the "No Surprises Act" topic at the end of this "Medical Coverage" section for important information regarding coverage of certain out-of-network items and services as in-network items and services effective May 1, 2022.

Covered Expenses for out-patient treatment include charges for treatment by Doctor of Medicine, Clinical or Child Psychologist holding a Ph.D., Clinical or Child Psychologist holding an M.A. or M.S.W. whose work is supervised by either an M.D., Ph.D. or Psy.D.; or a Licensed Therapist holding an M.A. or M.S.W. or similarly qualified professional working in their area of training as determined to be medically appropriate. You may contact T.E.A.M. for additional information with regard to whether a professional's services are medically appropriate.

- Intensive Outpatient Day Treatment

- Payment of Benefits. The Plan will pay for Covered Expenses incurred during treatment sessions under the Intensive Outpatient Day Treatment program according to the following restrictions:

- Provisions Governing Intensive Outpatient Day Treatment. Medication management is reimbursed without a deductible. All other covered mental health expenses are subject to the deductibles described in the Schedule of Benefits. Benefits are payable for four methods of treatment for mental health conditions.

    1. *Full-Time Inpatient Treatment.* The Plan will pay for full-time inpatient confinement in a Hospital or in an approved Treatment Facility. After the Eligible Individual pays the deductible specified in the Schedule of Benefits, the Plan pays Room and Board Charges and other Hospital charges as specified in the Schedule of Benefits. The deductible does not apply to medication management.

    2. *Partial Hospitalization.*

    3. *Intensive Outpatient Day Treatment.* The Plan will pay for therapeutic involvement as specified in the Schedule of Benefits.

    4. *Outpatient Treatment.* After the Eligible Individual pays the deductible specified in the Schedule of Benefits, the Plan will pay benefits as specified in the Schedule of Benefits.

♦ Behavioral disorders, such as Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) will also be covered as specified in the Schedule of Benefits.

Treatment of Chemical Dependency

Type of Service	Procedure
Outpatient Chemical Dependency	The Eligible Individual's provider submits the claim and the claim is paid at the highest level of benefits.
Inpatient Chemical Dependency	**In-network** providers must notify Optum of any required admissions. Out-of-network providers must also notify Optum of any required admissions and certify that treatment is Medically Necessary. However, if the treating Physician will not contact Optum, the Eligible Individual must contact Optum to ensure maximum benefits. Optum will send a copy of the certification or notice to the Fund Office. Optum will then take the lead role in co-managing the case. The provider submits the claim for the Eligible Individual, and the claim is paid at the highest level of benefits.

Inpatient services require a deductible (specified in the Schedule of Benefits).

Please see the "No Surprises Act" topic at the end of this "Medical Coverage" section for important information regarding coverage of certain out-of-network items and services as in-network items and services effective May 1, 2022.

Benefits are payable for inpatient and outpatient treatment as explained below:

- **Inpatient Treatment**. Care must be received in a Hospital or an approved Treatment Facility. An approved Treatment Facility is one that is accredited by the Joint Commission on Accreditation of Health Care Organizations or one which meets certain requirements established by the Trustees.

    - An Eligible Individual will be entitled to receive treatment for alcoholism and/or drug addiction provided the Eligible Individual is Covered Under the Plan at the time a course of treatment is received.

    - The program is licensed by the State of Minnesota, or if in a program in another state, the program is licensed in that state or is determined to be medically appropriate.

    - The treatment is in a licensed or accredited Hospital.

    - The community health center or mental health clinic is approved or licensed by the Commissioner of Public Welfare or other authorized state agency.

    - The treatment or service is pursuant to a court Order.

    - Such confinement is evaluated and determined to be Medically Necessary by Optum.

- **Partial Hospitalization Treatment**

    - Payment of Benefits. The Plan will pay for Covered Expenses incurred during treatment sessions under the Partial Hospitalization program.

Covered Expenses

Covered Expenses for in-patient treatment include charges for treatment by a Doctor of Medicine, Clinical or Child Psychologist holding a Ph.D. or Psy.D.; Clinical or Child Psychologist holding an M.A. or M.S.W. whose work is supervised by either an M.D. or Ph.D.; or a Licensed Therapist holding an M.A. or M.S.W. degree as determined to be medically appropriate. You may contact T.E.A.M. for additional information with regard to whether a professional's services are medically appropriate.

The following in-patient treatment benefits are paid:

- **Detoxification Treatment.** Medical care for detoxification will be covered. After the Eligible Individual pays the deductible, the Plan pays Room and Board Charges plus eligible Hospital charges as specified in the Schedule of Benefits.

- **Rehabilitative Treatment.** Consultation and group therapy for rehabilitative treatment are covered as specified in the Schedule of Benefits for Mental Health and Chemical Dependency Benefits.

- **Outpatient Rehabilitative Treatment and Aftercare.** The Plan covers individual, group, and family therapy. After the Eligible Individual pays the deductible, the Plan pays the Reasonable and Customary Charges as specified in the Schedule of Benefits. Plan benefits are not available unless:

  - The program is licensed by the State of Minnesota;

  - The treatment is in a licensed or accredited Hospital;

  - The community health center or mental health clinic is approved or licensed by the Commissioner of Public Welfare or other authorized state agency;

  - The treatment or service is pursuant to the diagnosis and/or recommendation of a Doctor of Medicine, a licensed Alcohol or Drug Counselor, a Clinical or Child Psychologist holding a Ph.D. or Psy.D. or a Clinical or Child Psychologist holding an M.A. or M.S.W.as determined to be medically appropriate. You may contact Optum. for additional information with regard to whether a professional's services are medically appropriate;

  - Covered Expenses for outpatient treatment include charges for treatment by Doctor of Medicine, Clinical or Child Psychologist holding a Ph.D., Clinical or Child Psychologist holding an M.A. or M.S.W. whose work is supervised by either an M.D., Ph.D. or Psy.D. or a Licensed Therapist holding an M.A. or M.S.W. degree as determined to be medically appropriate. You may contact Optum for additional information about whether a professional's services are medically appropriate; and

  - Such consignment is evaluated and determined to be Medically Necessary.

Medication management, whether in conjunction with inpatient or outpatient services, is paid as specified in the Schedule of Benefits with no deductible.

For inpatient and outpatient care, services of a licensed Physician, psychologist, M.A., or M.S.W. when providing treatment under the supervision of a medical Physician (M.D. or doctor-level psychologist [Ph.D.]).

Mental Health and Chemical Dependency Benefit Exclusions and Limitations

All benefits for psychiatric in-patient and out-patient care not specifically excluded must be determined based on the attending Psychiatrist's or Psychologist's report. No benefits will be allowed until such time as these reports are reviewed by the Fund Office or T.E.A.M.

The Plan will not pay any of the following expenses:

1. Charges excluded from the medical expense benefit, unless specifically provided as a mental health or chemical dependency benefit;

2. Any charge or portion of a charge that is in excess of a Reasonable and Customary Charge or in excess of the Schedule of Benefits;

3. Any charge for inpatient treatment in a facility that does not meet the Plan's definition of a Hospital, or in a treatment facility that is not approved by the Trustees;

4. Any expense that is excluded under the Plan's medical benefits under the "Medical Expense Limitations and Exclusions" section;

5. Charges incurred for treatment and diagnosis of learning disabilities;

6. Charges incurred for treatment by a provider who does not meet the requirements of this benefit;

7. Charges for any course of treatment terminated before completion;

8. Any charge beyond the maximum benefits stated in the Plan;

9. Any program of treatment for alcoholism or drug addiction that includes aversion treatment;

10. Charges for Methadone treatment unless pursuant to an approved Medical Necessity Authorization.

No Surprises Act: Special Rules Effective May 1, 2022

Effective May 1, 2022, subject to the Plan's standard cost sharing requirements and coordination of benefits rules, the Plan will cover certain claims for out-of-network items and services as if the items and services were provided by an in-network provider (i.e., your coinsurance will be the in-network rate and you will not be subject to balance billing). This rule applies only to: (i) claims for Emergency Services provided by an out-of-network provider and/or at a non-Participating Health Care Facility; (ii) claims for certain non-Emergency Services furnished to you by an out-of-network provider at a Participating Health Care Facility; and (iii) claims for out-of-network Air Ambulance Services. The exact costs payable by you and the Plan for such claims will be determined in accordance with rules and regulations established and in effect at the relevant time pursuant to the Consolidated Appropriations Act, 2021.

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

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

  ► The attending Emergency Physician or treating provider determines that the patient is able to travel using nonmedical transportation or non-Emergency medical

transportation to an available in-network provider or Participating Health Care Facility located within a reasonable travel distance, taking into account the patient's medical condition; and

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

1. If the Hospital or Independent Freestanding Emergency Department is a Participating Health Care Facility but the provider is an out-of-network provider, the written notice must contain a list of any in-network providers at the Participating Health Care Facility who are able to furnish the items and services involved and must notify the patient that he or she may be referred, at his or her option, to such an in-network provider; or

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

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

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

  ► Ancillary services, which are:

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

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

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

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

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

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

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

- Providing the patient with a written notice within the time frame noted below, in paper form or, as practicable, electronic form (as selected by the patient), provided separately from other documents, and containing the following information:

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

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

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

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

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

- Providing the written notice:

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

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

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

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

  2. State that by signing the consent, the patient agrees to be treated by the out-of-network provider and understands that he or she may be balance-billed and subject to cost sharing requirements that apply to services furnished by the out-of-network provider; and

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

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

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

♦ **Out-of-Network Air Ambulance Services**

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

- These rules only apply if the Air Ambulance Services meet all of the generally applicable criteria described above in the Schedule of Benefits for coverage of Medically Necessary Air Ambulance Services.

RETIREE COVERAGE

Retiree Coverage in the Plan is not an "accrued benefit." The Trustees reserve the right, at any time and in their sole discretion, to increase the Retiree Contribution rate, to reduce plan benefit coverage for Retirees and their Dependents, and to completely terminate plan benefit coverage for Retirees and their Dependents. Depending upon which plan you choose at retirement, information will be provided to you by the Fund Office.

Retiree Coverage may include medical, prescription drug, vision, and dental benefits, depending on when you retire, but never includes loss of time benefits, maternity leave benefits, accidental dismemberment benefits, life insurance, the accrual of Premium Credits, orthodontic and, other than restorative dental benefits, non-preventative dental benefits. Retiree dental benefits are a preventative care benefit only plus 10% of restorative of Delta Dental's amounts.

When an Eligible Employee retires, there are three alternative ways to continue Plan coverage:

1. **Through COBRA Continuation Coverage.** Continuation Coverage is available for up to eighteen (18) months for you (or up to twenty-nine (29) months if you are disabled) and thirty-six (36) months for your Eligible Dependents, provided you make the correct COBRA Continuation Coverage payments to the Fund Office on time. A Retiree may elect to continue Plan coverage through COBRA Continuation Coverage in addition to the two other alternative ways to continue Plan coverage that are described below, but the timing and availability of such Continuation Coverage depends on factors such as the terms of the Collective Bargaining Agreement under which you became eligible to participate in the Plan and the amount of any Premium Credits you may have. Refer to the "Continuation Coverage " section in this Plan for more information.

2. **Through Premium Credits and Self-Contributions.** If an Eligible Retiree and all Eligible Dependents meet the additional requirements listed below, Retiree Coverage is available for you and your Eligible Dependents by first exhausting any remaining Premium Credits in your Premium Credit Account, and second, by Self-Contributions, as long as you make the correct Self-Contributions on time.

3. **Through Medicare Supplements.** When an Eligible Employee is eligible for Medicare, the Eligible Employee may choose to enroll in the Medicare Advantage and Prescription Drug coverage sponsored by Humana and made available through this Plan, or augment his or her Medicare benefits through an array of supplemental programs provided through various insurance companies.

To be considered eligible for Retiree Coverage under this Plan, an Eligible Employee must retire on or after reaching age fifty-five (55), at the time of application for Retiree Coverage must not be on any out-of-work lists maintained by any local union affiliated with the I.B.E.W., must make any necessary Self-Contributions, and must:

1. Retire directly from employment covered by the Plan (including employment covered by the Plan under a Collective Bargaining Agreement or Participation Agreement that requires a flat-rate monthly premium to be paid by your Employer for your coverage) and after being an active Member Covered Under the Plan for at least two (2) of the five (5) consecutive years immediately preceding retirement; or

2. Retire directly from Alternative Employment after being an active Member Covered Under the Plan for at least fifteen (15) years and after working in Alternative Employment for at least two (2) of the five (5) consecutive years immediately preceding retirement; or

3. Without prior notice to the Plan, retire directly from working for a Union-affiliated employer that contributes to the Plan after being an active Member Covered Under the Plan for at least two (2) of the five (5) consecutive years immediately preceding retirement; or

4. Retire directly from employment as an electrical inspector or electrical instructor after being an active Member Covered Under the Plan for at least fifteen (15) years and continuously covered under an employer-sponsored group health plan; or

5. 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. at the time of your application for Retiree Coverage, you are not considered retired and are not eligible for Retiree Coverage under this Plan. If you are already an Eligible Retiree Covered Under the Plan's Retiree Coverage, however, you will not lose your eligibility for Retiree Coverage merely because you subsequently are on an out-of-work book, consistent with the Suspension of Retiree Coverage for Prohibited Employment rules in this "Retiree Coverage" section.

For purposes of eligibility for Retiree Coverage:

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 from Covered Employment because of Permanent and Total Disability;
        iii. Maintains eligibility, as a Member covered under the Inside Agreement, through Premium Credits, followed by Self-Contributions (with or without an intervening period of COBRA Continuation Coverage); or
        iv. Maintains eligibility under the COBRA Continuation Coverage provisions of the Plan for Non-Bargaining Unit Employees, Flat-Rate Bargaining Unit Employees (as defined below), and Limited Energy Agreement Bargaining Unit Employees.

    The term "Flat-Rate Bargaining Unit Employee" in paragraph 1(b)(iv) immediately above, regarding eligibility for Retiree Coverage following a period of COBRA Continuation Coverage, means either (a) a Bargaining Agreement Employee who is Covered Under the Plan under a Collective Bargaining Agreement that requires the Employer to make flat-rate monthly Contributions to the Plan on behalf of its Employees; or (b) a Bargaining Unit Employee who is Covered Under the Plan under a Participation Agreement that requires the Employer to make flat-rate monthly Contributions to the Plan on behalf of its 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 Coverage 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) 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.

Years Under the Plan will be computed in whole and partial years. Periods under paragraphs 1, 2, 3, and 4, above, may be cumulated to calculate your Years Under the Plan.

Option to Temporarily Opt-Out of Retiree Coverage

If you are eligible to obtain Retiree Coverage, you and/or your Spouse may exercise an opt-out provision if you and/or your Spouse have other coverage available through your Spouse at the time you retire. If you or your Spouse wish to exercise this opt-out provision of the Retiree Coverage, you must meet the following additional requirements:

1. *If both of you opt-out:* At the time of your retirement and your election to temporarily opt-out of Retiree Coverage, you must be covered by your Spouse's employment-based group health coverage or by a government-sponsored health coverage, such as health coverage provided by the Veterans Administration. You will be allowed to opt back into Retiree Benefits coverage under this Plan only if (a) you and/or your Spouse loses coverage due to retirement, termination of employment (voluntary or involuntary), reduction in hours, involuntary loss of government-sponsored health coverage, or death of your spouse, and (b) such coverage was continuous from the date of opt-out to the date of opt-in. You will not be allowed to opt back into Retiree Coverage if the other coverage is lost for any other reason, such as a voluntary choice to drop the other coverage, or if the coverage was not continuous from the date of opt-out to the date of opt-in. If you die, the spouse will not be permitted to re-enroll in the Plan at any time in the future.

2. *If only your Spouse opts-out:* At the time of your retirement, your Spouse may elect to temporarily opt-out of Retiree Coverage if they are covered by their own employment-based group health coverage or by a government-sponsored health coverage, such as health coverage provided by the Veterans Administration. Your Spouse will be allowed to opt back into Retiree Benefits coverage under this Plan only if (a) your Spouse loses coverage due to retirement, termination of employment (voluntary or involuntary), reduction in hours, or involuntary loss of government-sponsored health coverage, and (b) such coverage was continuous from the date of opt-out to the date of opt-in. Your Spouse will not be allowed to opt back into Retiree Coverage if the other coverage is lost for any other reason, such as a voluntary choice to drop the other coverage, or if the coverage was not continuous from the date of opt-out to the date of opt-in. If you die, the Spouse will not be permitted to re-enroll in the Plan at any time in the future.

If you or your Spouse would like to take advantage of this Plan option to opt-out of Retiree Coverage, you will be required to:

1. Notify the Plan Administrator in writing of your election to temporarily opt-out of Retiree Coverage within thirty (30) days of the date of your retirement and provide documentation acceptable to the Plan Administrator that you are covered under your Spouse's health plan or under government-sponsored health coverage. Your earliest possible effective date of the opt-out under this Plan will be on the 1st day of the month following the thirty (30) days of the Plan Administrator's receipt of the written request to opt-out, along with the other required documentation described above.

2. Notify the Plan in writing of your election to opt back into coverage under this Plan within thirty (30) days of the date of the following qualifying events:

    a. 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;

    b. A significant increase in the cost you pay (defined as an increase of fifty percent (50%) or more per month) for coverage available through a Spouse; or

    c. You are no longer eligible as a dependent under your Spouse's plan due to divorce or legal separation (in which case you may re-enroll yourself only).

3. There can be no break in health care coverage between:

    a. Your Spouse's terminating coverage (or your terminating government-sponsored health coverage, as the case may be); and

    b. The beginning of your Retiree Coverage under this Plan.

    Therefore, you may be required to elect and pay for COBRA or COBRA-style continuation coverage under your Spouse's health care plan or government-sponsored health coverage from the date your other coverage terminates to the date your Retiree Coverage begins under this Plan.

4. If you qualify to opt back into Retiree Coverage, all of the requirements concerning Retiree Coverage will apply, such as Self-Contributions requirements.

Option to Temporarily Opt-Out of Retiree Coverage to Seek Coverage through the Health Insurance Exchange

If you have or are eligible to obtain Retiree Coverage but are not yet eligible for Medicare, you may exercise an opt-out provision to obtain private coverage through a health insurance exchange ("exchange") established under section 1311 of the Affordable Care Act. The exchanges, also called "health insurance marketplaces," are online tools established and maintained by the government that you can use to find health insurance and make side-by-side comparisons of health insurance policies offered by private companies.

You are only able to exercise this opt-out provision during an exchange's annual open enrollment period.

If you would like to take advantage of this opt-out provision, you will be required to:

1. Notify the Plan Administrator in writing of your election to temporarily opt-out of Retiree Coverage and provide all requested documentation. Your earliest possible effective date of the opt-out under this provision will be the 1st day of the month following thirty (30) days of the Plan Administrator's receipt of your written request and all required documentation; and

2. Notify the Plan in writing of your election to opt back into coverage under this Plan when you become Medicare eligible.

By electing to opt-out of coverage to obtain private health insurance coverage through the exchange, you will:

1. Not be entitled to any benefits or other payments from the Plan, including, but not limited to, health care benefits, dental benefits, accidental death and dismemberment benefits, extended coverage options under federal law, or Retiree Coverage unless and until you have successfully opted back into Plan coverage upon becoming Medicare eligible; and

2. Upon returning to coverage under the Plan, forfeit any Retiree Coverage rate discount to which you may have previously been entitled under the Plan.

Option to Opt-Out of Retiree Dental Coverage

If you are a Retiree who is seeking a different level of dental coverage than is provided under the Plan, you may elect to opt-out of the Plan's dental coverage. This is a onetime opt-out provision, meaning you will not be permitted to re-enroll in the Plan's dental coverage in the future under any circumstances. Eligible Dependents, however, may elect dental coverage under the Plan even if the Retiree opts out of coverage. Eligible Dependents who opt out of the Plan's dental coverage are also subject to the onetime opt-out provision and will not be permitted to re-enroll in the Plan's dental coverage in the future under any circumstances. If you would like to take advantage of this opt-out provision, you will be required to:

Notify the Plan Administrator in writing of your election to opt-out of dental coverage. Your earliest possible effective date of the opt-out under this provision will be the 1st day of the month following thirty (30) days of the Plan Administrator's receipt of your written request to opt-out.

Types of Retiree Coverage

The types of coverage available to you and your Dependents will depend on when you Retire as follows:

Pre-Medicare Retirees (Age 55 Through 64)	You are able to continue your medical, prescription drug, vision and preventive dental coverage for yourself and Eligible Dependents. You may also continue restorative dental coverage equal to 10% of Delta Dentals' allowed amount, up to a maximum of $500 per Calendar Year.*
Medicare-Eligible Retirees (Age 65 and Over)	Your medical and preventive dental coverage is provided under Humana's Medicare Advantage and Prescription Drug program, which is a separate program that is not part of the Plan. You also have restorative dental coverage equal to 10% of Delta Dentals allowed amount, up to a maximum of $500 per Calendar Year.*
**The Calendar Year maximum does not apply to diagnostic and preventive dental care, dental exams, or dental cleanings for Eligible Individuals under age 18.*	

All benefit payments for restorative dental coverage charges incurred in a Calendar Year count against that Calendar Year maximum benefit for restorative dental coverage, including payments related to charges incurred while you were Covered Under the Plan as an active Employee and Retiree.

Preventive dental coverage not provided by a Medicare Advantage plan is provided by Delta Dental.

Coverage for You and Your Eligible Dependents

At the time of retirement, you may choose to continue coverage or to drop coverage for yourself and/or for your Eligible Dependents. If you choose to drop coverage and you are not covered under another health care plan at the time of your retirement, you may not enroll yourself or your Dependents for coverage under the Plan at a later date.

Your Spouse may continue coverage if you were married for the twelve (12) month period immediately preceding your retirement and you are not continuing your coverage after your retirement. If you become married less than twelve (12) months before your retirement or after your retirement, your Spouse will be ineligible for coverage under the Plan.

If you are a Retiree and become eligible for Medicaid, your Dependent Spouse may continue coverage under the Plan beginning on the first day your Medicaid coverage is effective, subject to the Plan's eligibility and self-Contribution requirements.

If you and/or your Dependents are covered under another health care plan at the time of your retirement, you may choose to decline coverage under this Plan until you wish to become reinstated or until you begin receiving Medicare benefits. You may also defer enrollment in the Plan's Medicare Supplement until you are no longer covered under another health care plan. To be eligible for reinstatement of your coverage, however, you must be able to show proof that you were continuously covered under another health care plan from the date your coverage under this Plan terminates until the date of your reinstatement or enrollment, or until you begin receiving Medicare benefits. If you choose to apply for reinstatement, you must contact the Fund Office.

Coordination of Benefits with Medicare

This Plan coordinates benefits with Medicare (you must enroll in both Parts A and B) when you or your Spouse become eligible for it. Benefits payable under this Plan will be reduced by any amounts paid under Parts A or B of Medicare. In no event will benefits paid by the Plan exceed the applicable amounts stated in the Schedule of Benefits, nor will the combined amounts payable under Parts A and B or Medicare and the Plan exceed the Covered Expenses incurred by the Eligible Individual as the result of any one Injury or Sickness. Benefits payable by these Parts of Medicare include benefits which would have been payable if the Eligible Individual had properly timely enrolled. Here's how the Plan works with Medicare to pay your medical benefits:

- **Pre-Medicare Retirees (Ages 55 Through 64).** If an Eligible Family Member is entitled to Medicare for reasons other than being 65 or older, Medicare will usually pay first on that Eligible Family Member's claims, and this Plan will pay second.

- **Medicare-Eligible Retirees (Aged 65 and Over).** This Plan will coordinate its benefits with Medicare when you have a claim. If you are covered as an Employee, the Plan will typically pay first and Medicare second. If you have a Medicare Advantage Plan through Humana, that Medicare Advantage Plan will pay in lieu of this Plan or traditional Medicare.

However, federal law may require this Plan to pay first as explained below:

- **For Eligible Employees Under Age 65 (including their Dependents Only).** 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 Fund Office to find out if this rule applies to your claim.

- **For Eligible Individuals eligible for Medicare by Reason of End Stage Renal Disease (ESRD) and Covered Under this Plan Through Self-Contributions or Employer Contributions.** Eligible Individuals who are ESRD Medicare-eligible will receive benefits as follows:

  - Benefits payable under the Plan will be limited to the covered charges incurred during the initial 30 consecutive months of treatment, beginning with either: (1) the first month in which renal dialysis treatment is initiated; or (2) in the case of an organ or bone marrow transplant, the first month in which the Eligible Individual could become entitled to Medicare, providing a timely application was filed. The Plan will be primary for these covered charges.

  - Benefits payable under the Plan beginning with the thirty-first (31st) month of treatment will be reduced by the amount of benefits paid or payable under Part A or Part B of Medicare. Medicare will be primary at this point.

- **For Employees or Members Continuing to Work After Age 65.** If you continue to work for a contributing employer after you become age 65 and are eligible for Medicare, you are entitled to the same benefits as Employees (Members) under age 65 as long as you meet the regular eligibility rules unless you receive retirement benefits under the provisions of a pension plan negotiated or sponsored by the I.B.E.W. This Plan will be your primary provider of health care benefits while you are employed. Medicare will pay secondary benefits only for expenses covered by it which are not paid by this Plan.

- **For Dependent Spouses Ages 65 or Older.** If your Dependent Spouse is age 65 or older while you are still working, this Plan will pay its normal benefits for your Spouse before Medicare pays. If your Spouse is covered under his or her own plan, that plan will pay first, this Plan will pay second and Medicare will pay last.

Enrollment in Medicare

You and your Spouse are each responsible for enrolling in Medicare Part A and Part B. Part A provides benefits for inpatient expenses and certain other expenses. Part B provides benefits for Physicians, diagnostic x-rays and lab tests, etc. The government makes a monthly charge for Part B.

If you stop working at or before age 65 and do not enroll in Part B within certain time limits, there is a penalty--you must pay a higher amount for Part B when you do enroll. However, if you continue to work after age 65 and stay Covered Under the Plan, there is no late enrollment penalty if you enroll within certain time limits after you stop working.

Medicare Advantage and Prescription Drug Coverage (Available through Humana)

You have the option of obtaining Medicare Advantage and Prescription Drug coverage through Humana and paying a premium for that coverage through the Plan if you are a Medicare-Eligible Retiree over the age of 65. The Medicare Supplemental coverage is available through Blue Cross Blue Shield of Minnesota. When you have a Medicare Advantage and Prescription

Drug Plan, that policy will pay in lieu of traditional Medicare and this Plan. Contact the Fund Office to learn more about the Medicare Advantage coverage option available through the Plan.

Payment of Self-Contributions for Retiree Benefits

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

- You must make your first Self-Contribution on or before its due date. Then there will be no lapse in coverage as an Eligible Employee and as an Eligible Retiree or Employee coverage and Retiree Benefits coverage.

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

- The Self-Contribution rate will equal 10% of the actual cost of coverage for Retirees who have completed thirty (30) years of service as determined by the Trustees less a discount. The discount is equal to the amount otherwise due times 2.5% times of the number of years you were Covered Under the Plan as an Eligible Employee or your Years Under the Plan (up to a maximum of 30 years), if you retired on or after September 1, 2003.

- If you predecease your Dependent Spouse prior to obtaining Retiree Coverage, the Self-Contribution rate your Dependent Spouse will pay when eligible for Retiree Coverage will be the percentage of the actual cost of coverage that you would have been charged for Retiree Coverage had you not predeceased your Dependent Spouse, provided your Dependent Spouse has maintained continuous coverage under the Plan prior to his or her eligibility for Retiree Coverage.

- Even so, you will be ineligible for this discount if you work at a job that entitles you to group health plan coverage (regardless of whether enrollment in such group health plan coverage is mandatory or would require you to pay a premium and regardless of whether you actually enroll in such group health plan coverage).

- If you are Medicare-eligible, the cost of your Self-Contribution will be determined annually by the Board of Trustees.

- The Fund Office must receive each Self-Contribution payment no later than the first day of the benefit month for that month's coverage. For example, to be covered for Retiree Benefits during the March benefit month, your Self-Contribution payment must be received no later than March 1st.

- If your Self-Contribution is not received by the Fund Office on or before its due date, your 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.

- Once a Self-Contribution payment has been accepted by the Fund Office, it will not be returned.

Using Your Premium Credit Account for Retiree Coverage

The amount of any particular month’s Self-Contribution will be reduced if you have a Premium Credit Account balance at the time that Self-Contribution is due. The amount of the reduction

will be equal to the percentage of the Self-Contribution otherwise due. The percentage will be equal to the percentage of one month's active Employee coverage that the balance would have covered, and your Premium Credit Account will be reduced as if paying for such active Employee coverage.

Note: There is a lifetime maximum of nine (9) months' worth of Premium Credits that may be applied against your costs for Retiree coverage. For purposes of this subsection, this lifetime maximum will be applicable upon the Participant's commencement of retirement benefits under the provisions of a pension plan negotiated or sponsored by the I.B.E.W. Once you have commenced benefits from an I.B.E.W. negotiated or sponsored pension plan and have Retiree coverage under his Plan, your Premium Credit Account balance, up to the maximum of nine (9) months' worth of Premium Credits, will be applied towards your costs for Retiree coverage.

For example, imagine Jane retires with six (6) months' worth of Premium Credits. Jane may use those credits to pay for six (6) months of Retiree Benefits (reducing her Premium Credit Account to zero (0) months' worth of Premium Credits).

However, imagine Joe retires with twelve (12) months' worth of Premium Credits. Joe then uses those credits to pay for nine (9) months of Retiree Benefits (reducing his Premium Credit Account to three (3) months' worth of Premium Credits). Joe could not use more than nine (9) months' worth of Premium Credits because it would exceed his lifetime maximum.

Termination of Coverage for Retirees and Their Dependents

Benefits for an Eligible Retiree under this Plan will end on the first to occur of the following:

- The date the Trustees terminate this Plan;
- The date the Trustees terminate Plan benefits for Retirees;
- The last date of the benefit month preceding the benefit month for which you do not make a proper and on-time Self-Contribution;
- The date the Eligible Retiree fails to comply with any condition of participation or Plan rules;
- The date the Eligible Retiree makes a fraudulent misstatement regarding eligibility or claims;
- The date the Eligible Retiree's coverage is effectively rescinded;
- The date on which the Retiree's eligibility for Plan coverage would terminate under the Plan for any other reason; or
- The date of your death.

Benefits for your Eligible Dependents will end on the first to occur of the following dates:

- The date the Trustees terminate this Plan;
- The date the Trustees terminate Plan benefits for Retirees;

- The date the Trustees terminate Dependent Benefits under this Plan;

- The date the Dependent Spouse enters the armed forces of any country on a full-time basis;

- The date the Dependent Child ceases to meet this Plan's definition of Dependent because he or she becomes eligible to enroll in an eligible employer-sponsored health plan other than the group health plan of a parent, including TRICARE in the case of a government employee;

- The date on which the Retiree's or Dependent's eligibility for Plan coverage terminates under the Plan for any reason other than his or her death;

- The date the Dependent ceases to meet this Plan's definition of a Dependent under the Plan unless the Dependent is entitled to enroll and does enroll for continuation coverage (refer to the "Continuation Coverage" section in this handbook);

- The date the Eligible Dependent fails to comply with any condition of participation or Plan rules;

- The date the Eligible Dependent makes a fraudulent misstatement regarding eligibility or claims;

- The date the Eligible Dependent's coverage is effectively rescinded;

- In the event of your death while making Self-Contributions for Retiree benefits, Eligible Dependent coverage will end:

    - 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;

    - When your surviving Spouse is making Self-Contributions to continue benefits on his or her behalf and for any Dependent Children, coverage ends:

        1. When the Fund Office does not timely receive a correct Self-Contribution on behalf of the Dependent;

        2. The date the Child ceases to meet the Plan's definition of a Dependent;

            ► For the surviving Spouse, the date the surviving Spouse remarries or dies, whichever occurs first; or

            ► The date on which Dependent's eligibility for the Plan terminated under the Plan for any other reason.

        3. For the Dependent Child in the event of the surviving Spouse's death, 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 Child.

- When Dependent Benefits are continued and there is no surviving Spouse, benefits end:

    1. When the Fund Office does not timely receive the correct Self-Contribution on behalf of the Child;

    2. The date the Child ceases to meet the Plan's definition of a Dependent;

    3. At the end of the last day of the last month of the 18-month period for which the Child was entitled to continue coverage and for which correct and timely Self-Contributions have been made; or

    4. The date on which the Dependent's eligibility Plan coverage would terminate under the Plan for any other reason.

Suspension of Retiree Coverage

Prohibited Employment. Retiree coverage for you and your Dependents under this Plan will be suspended if you perform more than thirty-nine and one-half (39½) hours per month of work:

- That is subject to a Collective Bargaining Agreement negotiated by, signed by, or otherwise involving the International Brotherhood of Electrical Workers (the "I.B.E.W.") or any of its affiliated local unions or any similar type of work (regardless of whether your particular work is the subject of any collective bargaining agreement);

- That is considered Covered Employment or that does or would entitle you to Contributions to or benefits under this Plan or that is the kind of work performed by an individual who is covered by (or is entitled to be covered by) this Plan or any similar type of work;

- As an electrician for any federal, state, or local or other subdivision of government;

- In the geographic area covered by the Plan;

- For an employer that is signatory to a Collective Bargaining Agreement with the I.B.E.W. (or with any of its affiliated local unions) or for an employer that is not such a signatory but that is similar to the types of employers who are such signatories, if the work is in a supervisory, managerial, estimating, or other non-bargaining position.

Prohibited Employment does not include any amount of work as: (i) an instructor in an apprenticeship program recognized by NECA and I.B.E.W. where instructors are not contributed upon; (ii) an electrical inspector conducting an electrical inspection on behalf of a municipal, state, county, or governmental authority where electrical inspectors are not contributed upon; or (iii) an instructor at a state or federal accredited school that confers at least an associate of arts degree related to the electrical industry.

Retiree Coverage for you and your Dependents under this Plan will not be suspended if you return to work under Covered Employment and perform less than thirty-nine and one-half (39½) hours per month or less than six hundred (600) hours per year of work. In such case, Premium Credits will be used to pay premium rates. Any excess Premium Credits received will be credited to the Plan's general operating fund.

Retiree Coverage will not be suspended merely because you are on an out-of-work book after commencing Retiree Coverage, but you are not allowed to commence Retiree Coverage at a time when you are on an out-of-work book.

Retiree coverage will not be suspended if you return to work under Covered Employment and work for the equivalent of not more than 600 hours during the period of June 1, 2020 through December 31, 2020.

Effective January 1, 2020, if you are receiving a disability benefit under this Plan, you will not be eligible to work under the 600-hour rule.

Geographic Limits. Effective January 1, 2020, the geographic area covered by the Plan is the State of Minnesota, plus the remainder of any Standard Metropolitan Statistical Area which falls partially within Minnesota. This geographic area may be changed by the negotiation in future Contribution Agreements, which require Employer Contributions to be made to the Plan.

Scope of Suspension. Suspension of Retiree Coverage includes the following:

- Elimination of the entire balance in your Premium Credit Account;
- Elimination of any right to apply an account balance under the Electrical Workers Local No. 292 Supplemental Unemployment Plan towards payment of premiums for Retiree Coverage under this Plan;
- Termination of all coverage under this Plan for you and your Eligible Dependents; and
- Elimination of any discount on the cost of Self-Contributions for Retiree Coverage.

Reinstatement. Any suspension of Retiree coverage is effective on the date you begin performing Prohibited Employment, regardless of when the Fund Office learns of the Prohibited Employment. The suspension is permanent. Even so, you may apply for reinstatement of the benefits suspended above, but only if the following two (2) conditions are satisfied:

1. You have permanently stopped performing any Prohibited Employment; and

2. The following number of months has passed since you last performed any Prohibited Employment:

   A number of months equal to: (a) one plus; (b) the number of months you performed Prohibited Employment.

Any reinstatement granted by the Trustees will be effective prospectively only. Reinstatement will not, for example, restore your Retiree coverage back to the date it was suspended. You will lose Premium Credits under your Retiree Coverage Premium Credit Account equal to the number of months you worked in Prohibited Employment.

Voluntary Termination Due to Other Retiree Coverage. An Eligible Member who voluntarily terminates Retiree coverage under the Plan may re-qualify for Retiree coverage only if the following two (2) conditions are satisfied:

1. The Eligible Member remained continuously covered under another Medicare supplement plan; and

2. The Eligible Member re-qualifies for active plan coverage through returning to employment.

DENTAL COVERAGE

If you have questions about the dental coverage, please call Delta Dental (651) 406-5900 or 1-800-533-9536 or the Fund Office. Our Delta group number is 6471.

Freedom of Choice

The Plan provides dental benefits regardless of the Dentist you choose, although your level of dental benefits under the Plan may vary based on the types of provider. Your Plan benefits will be better if you choose a Delta Dentist instead of an out-of-network Dentist and best if you chose a Delta Preferred Provider. In any event, Delta will not cover dental expenses in excess of $100 unless you get a predetermination of benefits from Delta, as described below.

Schedule of Dental Benefits

	Delta Preferred Network	Delta Premier Network	Out-of-Network
Deductible			
A deductible is the amount an Eligible Individual must pay annually, before the Plan begins to provide payment for services other than diagnostic and preventive care, Oral Surgery, or orthodontia. There is no family maximum dental deductible. An Eligible Individual must pay the deductible each Calendar Year, expenses incurred for orthodontia will not be used in satisfying the dental deductible.			
	Delta Preferred Network	**Delta Premier Network**	**Out-of-Network**
Member	$50	$50	$50
Dependent	$50	$50	$50
Family Maximum	No Maximum	No Maximum	No Maximum
Coinsurance			
Coinsurance is the percentage of the charges covered that each Eligible Individual is responsible for over and above benefits the Plan will pay. Dental deductibles may apply before coinsurance is applied. The Plan's dental coverage is 100%, 80%, and 60% (and your corresponding coinsurance is 0%, 20%, and 40%, respectively), depending on the types of services obtained and where obtained. In the case of services provided at a Delta Dentist, an Eligible Individual will be responsible for paying the coinsurance percentage of the discounted fees the Plan has negotiated with the Dentist. In the case of services provided by an out-of-network Dentist, the Plan's dental coverage will be limited to the applicable percentage of Delta's "allowed amount" even though the fees the Dentist actually charges an Eligible Individual will not be limited in any way by Delta.			

Maximum Limits			
Maximum limits are the maximum amounts payable to each Eligible Individual in the Plan.			
Annual Maximum for All Covered Dental Expenses (including Diagnostic and Preventive Care, Basic Services, Major Restorative Care and Prosthetics), this excludes Orthodontia.			
	Delta Preferred Network	**Delta Premier Network**	**Out-of-Network**
Per Person	$2,500	$2,500	$2,500
Orthodontia Lifetime Maximum			
Per Dependent Child Ages 19 and under	$2,000	$2,000	$2,000

To receive the maximum benefit levels listed on the following pages, an Eligible Individual must request a predetermination of benefits for any dental procedure that exceeds $100.

	Delta Preferred Network	**Delta Premier Network**	**Out-of-Network**
	Reasonable and Customary Plan Covered Charges		
Dental Benefits			
Diagnostic and Preventive Care	100%	100%	100% of Delta Dental's Allowed Amount
	Included as diagnostic and preventive care are: ♦ Exams and cleanings and periodontal scalings at six-month intervals (*as indicated above, benefits paid for these services count against the Annual maximum limit for all covered dental expenses, specified above;* ♦ Full-mouth x-rays at three-year intervals; ♦ Bitewing x-rays, once per year and other dental x-rays required or upon diagnosis a specific condition requiring treatment, not more than twice per Calendar Year; ♦ Fluoride treatment, at twelve-month intervals for covered Children who are under the age of 19; and ♦ Space maintainers for missing posterior primary teeth,		

<table>
<tr><th></th><th>Delta Preferred Network</th><th>Delta Premier Network</th><th>Out-of-Network</th></tr>
<tr><td rowspan="2">Basic Services</td><td>80%</td><td>60%</td><td>60% of Delta Dental's Allowed Amount</td></tr>
<tr><td colspan="3">Included as basic services are:

♦ Emergency treatment for relief of pain;

♦ Amalgam restorations (silver fillings);

♦ Anterior (front teeth) resin restorations (white fillings);

♦ Endodontics;

♦ Nonsurgical periodontics, at two-year intervals;

♦ Surgical periodontics, at three-year intervals;

♦ Surgical and nonsurgical extractions, including pre- and post-operative care; and

♦ Sealants for permanent molars of Eligible Dependent Children who are under the age of 26, limited to once per lifetime (per tooth);

Gold fillings are covered up to the cost of Reasonable and Customary restorative materials. Any costs above that Reasonable and Customary restorative material cost is the responsibility of the Eligible Individual.</td></tr>
<tr><th></th><th>Delta Preferred Network</th><th>Delta Premier Network</th><th>Out-of-Network</th></tr>
<tr><td rowspan="2">Major Restorative Care</td><td>80%</td><td>60%</td><td>60% of Delta Dental's Allowed Amount</td></tr>
<tr><td colspan="3">Included as major restorative care are:

♦ Crowns, at five-year intervals;

♦ Posterior (molars) resin restorations (white fillings), at two-year intervals;

♦ Simple extractions;</td></tr>
</table>

	♦ Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or accidentally broken teeth; ♦ General anesthetics when Medically Necessary and administered in connection with oral or dental surgery; ♦ Treatment of periodontal and other diseases of the gums and tissues of the mouth (non-surgical periodontic procedures are covered under the Plan at two year intervals and surgical periodontic procedures are covered at three year intervals); ♦ Endodontic treatment, including root canal therapy; ♦ Injection of antibiotic drugs by the attending Dentist; ♦ Repair or recementing of crowns, inlays, onlays, bridgework or denture after 12 months or relining or rebasing of dentures more than six months after the placement of an initial or replacement denture, but not more than one relining or rebasing in any period of 36 consecutive months; ♦ Inlays, onlays, gold fillings, or crown restorations to restore diseased or accidentally broken teeth, but only when the tooth, as a result of extensive caries or fracture, cannot be restored with an amalgam, silicate, acrylic, porcelain, or composite filling restoration; ♦ Initial placement of fixed bridgework (including inlays and crowns as abutments) provided the teeth, which are missing and will be replaced by the bridgework, were removed while Covered Under this Plan, and the abutment teeth, considered individually, require the recommended restoration; ♦ Initial placement of partial or full removable dentures (including precision attachments and any adjustment during the six-month period following placement); ♦ Replacement of an existing partial or full removable denture or fixed bridgework by a new denture or by new bridgework, or the addition of teeth to an existing partial removable denture or to bridgework, provided that it is required as the result of an Injury unrelated to your job if the denture or bridgework cannot be adequately repaired; ♦ Replacement of a full denture, when replacement is required as the result of a structural change within the mouth and is made more than five (5) years after the date of the placement of such denture, but not including any such replacement made less than two (2) years after the effective date of this benefit; (Normally, dentures will be replaced by dentures, but if a professionally

<table>
<tr><td></td><td colspan="3">adequate result can be achieved only with bridgework, charges for such bridgework will be included as Covered Dental Expenses);

♦ Charges for the placement of dental implants required due to a dental condition or disease are covered under All Covered Dental Expenses which is subject to an annual maximum benefit of $2,500; and

♦ Placement of dental implants, but only for the purposes of replacing dentition lost or irreparably damaged due to a medical condition or congenital defect or where dentition is not present due to a congenital defect. This coverage is subject to a lifetime maximum benefit of $10,000.</td></tr>
<tr><td></td><td>Delta Preferred Network</td><td>Delta Premier Network</td><td>Out-of-Network</td></tr>
<tr><td rowspan="2">Oral Surgery</td><td>100% up to the maximum available benefit</td><td>100% up to the maximum available benefit</td><td>100% of Delta Dental’s Allowed Amount up to the maximum available benefit</td></tr>
<tr><td colspan="3">Oral Surgery is any operative procedure performed on the teeth, mouth, or jaw which can be performed by a Dentist or oral surgeon.

Covered services include:

♦ Oral Surgery for certain procedures;
♦ Surgical tooth removal;
♦ Impacted wisdom tooth removal; and
♦ Cyst removal.

Hospitalization

Room and Board Charges and other Hospital services and supplies incurred for the above Oral Surgery procedures will be payable on behalf of an Eligible Individual who is confined as a Hospital in-patient for dental treatment only if a Physician who is an M.D. certifies in writing that the Hospital confinement for such treatment is Medically Necessary and subject to the Medical Schedule of Benefits.

Emergency Dental Treatment

♦ If a Dentist provides emergency dental treatment on behalf of an Eligible Individual, the Predetermination of Benefits Procedure will not be necessary.</td></tr>
</table>

<table>
<tr><td></td><td colspan="3">

If a Dentist must render additional treatment of a non-emergency nature in connection with a dental emergency, the Predetermination of Benefits Procedure must be followed.
If the charges for the additional treatment rendered in connection with the dental emergency will exceed $100, the Dentist must submit, along with the Predetermination of Benefits form and the other required information, the bill or other explanation of the emergency treatment which the Dentist rendered to the Eligible Individual.

Treatment for Injury to the Teeth and as a Result of Necessary Medical Treatment

The Plan will pay covered dental expenses for treatment by a Physician needed due to Injury to remove, repair, restore, or reposition natural teeth that were damaged, lost or removed. The treatment must be started no later than 12 months from the date of the accident causing the Injury.

The Plan will also pay covered dental expenses for treatment resulting from the effects of medical treatment which is Medically Necessary.

Notwithstanding the other lifetime maximum benefit limits identified under the Plan’s Dental Coverage provisions, the covered dental expenses described in this subsection will be subject to a combined lifetime maximum limit of $10,000.

If an Eligible Individual incurs Medically Necessary dental expenses as a result of Injury or congenital defect, AND the Eligible Individual also incurs medical expenses related to the same Injury or congenital defect, the dental services will be considered under the Medical Coverage under the Plan.

Dental services covered under this provision will be subject to the medical deductible and coinsurance and will not be subject to the annual dental maximum.

</td></tr>
<tr><td></td><td>Delta Preferred Network</td><td>Delta Premier Network</td><td>Out-of-Network</td></tr>
<tr><td>Orthodontia Benefits</td><td>100% up to the maximum available benefit</td><td>100% up to the maximum available benefit</td><td>100% of Delta Dental’s allowed Amount up to the maximum available benefit</td></tr>
</table>

	The Plan will cover orthodontia benefits for an Eligible Individual subject to the Plan's Orthodontia Lifetime Maximum Benefit specified in the Schedule of Dental Benefits and subject to the "Orthodontia Expenses Not Covered" section below. All payments made by the Plan under this Section during a Calendar Year on behalf of an Eligible Individual, excluding payments made for diagnostic and preventative dental care, dental exams, or dental cleanings for Eligible Dependents ages 18 and under, will apply against that Eligible Individual's Orthodontia Lifetime Maximum Benefits. Once the Plan has paid the Orthodontia Lifetime Maximum Benefit, the Eligible Individual will not be entitled to any further payments for charges incurred for orthodontia services regardless of the Medical Necessity for the treatment or services. Included in orthodontia services are actual charges incurred, including charges for: ♦ Minor appliance therapy; ♦ Full-banded orthodontics; ♦ Diagnostic procedures; ♦ Occlusal guards; ♦ Occlusal analysis; and ♦ Occlusal adjustments. The Plan will pay the Orthodontia Lifetime Maximum Benefit amount in two installments at a specified duration apart. 1. First Installment. The Plan will pay up to one-half of the Orthodontia Lifetime Maximum Benefit when the braces/appliances are installed. 2. Second Installment. The Plan will pay, as discussed below, the remaining portion of the Orthodontia Lifetime Maximum Benefit on a date 12 consecutive months after the first installment payment date. The amount of the first and second installment payments combined will not exceed the Orthodontia Lifetime Maximum Benefit. The Plan will pay the remaining portion of the Orthodontia Lifetime Maximum Benefit as follows: a. The Plan will first process and pay claims for covered orthodontia treatment and service charges actually incurred.

b. If the Orthodontia Lifetime Maximum Benefit has not been exhausted, the Plan will then pay any remaining orthodontia benefit to offset approved anticipated future orthodontic expenses as evidenced by a written treatment and payment plan from the treating orthodontist. The Eligible Individual must submit to the Fund Office for review a copy of the written treatment and payment plan before any benefits will be paid for any anticipated future orthodontic benefits. The amount paid under this paragraph b will not exceed the amount of anticipated future orthodontic expenses indicated in the written treatment and payment plan or the Orthodontia Lifetime Maximum Benefit. The Board of Trustees retains sole discretion in the approval and payment of anticipated future orthodontic expenses under this paragraph b.

Predetermination of benefits is not necessary for orthodontia treatment.

Orthodontia Expenses Not Covered

Covered Orthodontia Expenses will not include and no payments will be made by the Plan for:

- Charges incurred by an Eligible Individual once he or she has received Plan benefits aggregating the individual's Orthodontic Lifetime Maximum Benefit;
- Charges incurred by individuals age 18 and under who do not satisfy the definition of Dependent Child under the Plan;
- Charges incurred by an Eligible Individual age 19 or older which are not for treatment necessary to preserve dentition and gingival structure, are not performed to correct a functional defect, or other non-orthodontic treatment covered under the Plan has not been exhausted;
- Charges incurred by an Eligible Individual for which payments are due to the orthodontist before the Eligible Individual's effective date of benefits;
- Charges incurred by an Eligible Individual for which payments are due to the orthodontist after the Eligible Individual's eligibility for benefits under this Plan terminate; and

<table>
<tr><td></td><td colspan="3">♦ Charges incurred for any treatments, care, services or supplies which are in excess of any limitation specified in, or which are specified as not payable under “Benefit Plan Conditions, Limitations and Exclusions” or any other Plan provisions.

Orthodontic Treatment in Process on effective Date of Benefits

If an Eligible Individual is already undergoing orthodontic treatment on the Eligible Individual’s effective date of benefits, the Plan will only pay for orthodontic charges which are billed after the Eligible Individual’s effective date of benefits and only if the payments for such charges have a due date on or after the individual’s effective Date of Benefits.</td></tr>
<tr><td></td><td>Delta Preferred Network</td><td>Delta Premier Network</td><td>Out-of-Network</td></tr>
<tr><td rowspan="2">Prosthetics</td><td>80%</td><td>60%</td><td>60% of Delta Dental’s Allowed Amount</td></tr>
<tr><td colspan="3">It is important to read the following information closely, especially the time intervals and limitations. Included as covered prosthetic expenses are:

♦ Dentures (full and partial) at five-year intervals;

♦ Bridges, replacement at five-year intervals;

♦ Denture adjustments;

♦ Denture repairs;

♦ Tissue conditioning, rebasing and relining at two-year intervals;

♦ Re-cementing of bridges; and

♦ Bridge repair.</td></tr>
</table>

Note: See the Retiree Coverage section of this handbook for details on dental coverage available to Retirees and their Eligible Dependents.

Dental Benefit Details

How to Use Delta Dental Benefits

Before your appointment:

- Verify with Delta Dental that you select to see is a Delta Dentist.
- Ask your Dentist to submit a Predetermination of Benefits to Delta Dental. It will tell you what your financial responsibility will be for a service.

At your appointment:

- Present your Delta Dental ID or Medical ID card.

After your appointment:

- If your Dentist is not a Delta Dentist, you must submit your claim to Delta yourself.
- Review the explanation of benefits ("EOB") you receive from Delta. The EOB explains the deductible, coinsurance, and amount paid to the Dentist by the Plan, as well as your share of the bill.

Predetermination of Benefits

If your dental expenses are expected to be $100 or more, you need a pre-estimate (or "Predetermination of Benefits"). This procedure lets you and your Dentist know ahead of time what the Plan will pay and what part of the cost you must pay. An Eligible Individual must pay all charges beyond the predetermined benefit amount so it is best to have the predetermination done *before* treatment has begun. The final decision about the work to be done is, of course, the Eligible Individual's to make.

To receive a predetermination, have your Dentist complete the dental claim form which is available from Delta. Your Dentist itemizes the dental services which are necessary and the cost for each service on the dental claim form. Your Dentist should submit the completed form to Delta Dental for review, along with the complete examination and treatment record, including full-mouth x-rays and study models, a description of each necessary procedure, and the proposed charges for each procedure, including the charges for examination and diagnosis.

A licensed dental professional at Delta will determine the percentage of coverage and send the Eligible Individual and his or her provider an Explanation of Benefits (EOB) form so the Eligible Individual and his or her provider know what the participant's financial responsibility will be prior to the service.

A predetermination of benefits does not guarantee payment for dental benefits. Coverage is available only if you are an Eligible Member/Employee or Eligible Dependent at the time services are received.

Covered Dental Expenses

If you or an Eligible Family Member needs dental treatment, the Plan will pay covered dental Reasonable and Customary expenses for the treatment of the Illness or Injury. The Plan covers eligible dental services provided by a Doctor of Dental Surgery (D.D.S.) or a Doctor of Medical Dentistry (D.M.D.) for preventive dentistry, dental restorations, Oral Surgery and orthodontia.

Covered dental expenses are the actual Reasonable and Customary charges incurred by an Eligible Individual for services and supplies which are necessary for treatment of a dental condition.

Example of How Dental Benefits Are Paid

The following is an example of fees submitted for one porcelain crown payable at 80% and 60% under the Delta **Preferred and Premier** networks, respectively. Out-of-network providers would be paid at 60% of the Delta Dental allowable amount. The example assumes the deductible has been satisfied for the Premier and out-of-network providers. These are hypothetical expenses only and fees may vary based on your Dentist's actual fees and location. If you live outside Minnesota and do not have access to a Delta Dental provider, your benefits will be paid based on the Reasonable and Customary fees (also referred to as Delta's allowed amount) for the service provided based on the out-of-network provider schedule.

Submitted Fees - $525 for a Porcelain Crown			
*Delta dental network providers have agreed to **negotiated** fees for patients who utilize the Delta Dental network. If the cost of a service is over that negotiated fee, Delta Dental network provides **cannot** bill you for the amount over this negotiated fee. Non-participating (out-of-network) providers, however, **will** bill you for that additional amount (called balance billing).*			
	Delta Preferred Network	**Delta Premier Network**	**Out-of-Network**
A. Submitted Fees	$525	$525	$525
B. Delta's Allowable Charge	$350	$400	$400
C. Difference	$175	$125	$125
D. Benefit Level	80%	60%	60%
E. Delta's Payment (B x D)	$280	$240	$240
F. Your Coinsurance	(B – E) = $70	(B – E) = $160	(B – E) = $160
G. Your Balance Bill	$0	$0	$125
H. What you Owe	(B – E) = $70	(B – E) = $160	(B – E + F) = $285

Limitations and Exclusions

Please read this section carefully. The Plan will not pay any of the following dental expenses:

1. Charges incurred for treatment by anyone other than a Dentist, except that cleaning or scaling of teeth and topical application of fluoride may be performed by a licensed dental hygienist, if such treatment is rendered under the supervision and guidance of a Dentist;

2. Charges incurred for services and supplies that are partially or wholly cosmetic in nature (including charges for bleaching or personalization or characterization of dentures);

3. Charges incurred for the replacement of a lost, missing, or stolen prosthetic device;

4. Charges incurred for services or supplies which are for orthodontia treatment, except as outlined under the "Orthodontia Benefits" section;

5. Charges incurred for a duplicate prosthetic device or any other duplicate appliance;

6. Charges incurred for oral hygiene and dietary instruction;

7. Charges incurred for a plaque control program;

8. Charges incurred for or related to dental implants or implantology, except for the sole purpose of anchoring a full denture and as specifically provided under the “Major Restorative Care” section;

9. Athletic mouth guards;

10. Services or supplies received due to dental disease, defect, Injury or Illness due to declared or undeclared war, any act of war, service with any branch of the military forces for any country except as covered under Tricare;

11. Dental care or services paid for, furnished by, or at the direction of any governmental agency, but only to the extent paid for or furnished;

12. Charges incurred for dental procedures which are included as Covered Medical Expenses;

13. Charges incurred for prosthetic devices (including bridges and crowns) and the fitting thereof which were ordered while the individual was not eligible for dental benefits or which were ordered while the individual was eligible for dental benefits, but are finally installed or delivered to such individual more than 90 days after termination of eligibility;

14. Charges incurred by an Eligible Individual during a Calendar Year in excess of the dental Calendar-Year maximum benefit (orthodontics excluded) specified in this Dental Benefits Section or the separate Calendar-Year maximum benefit for Oral Surgery services specified in the Schedule of Dental Benefits;

15. Charges incurred for Hospital and related expenses in connection with an inpatient Hospital confinement for the purpose of dental treatment for which there exists no prior written certification by the Dentist and an M.D. that the inpatient confinement is Medically Necessary for such treatment;

16. Charges incurred for opening of vertical dimension except by special report and review;

17. Charges incurred for treatment which started while the individual was not eligible for dental benefits. Treatment is considered to begin:

    a. For full or partial dentures, when the impression is taken for the appliances;

    b. For fixed bridgework, crowns, and other gold restorations, when the tooth is first prepared; and

    c. For root canal therapy, when the tooth is opened except by special report and review;

18. Charges incurred for any occupational Injury or Sickness for which benefits are payable under any Worker's Compensation or occupational disease, act or law;

19. Charges incurred which do not meet the standards of dental practice accepted by the American Dental Association;

20. Charges incurred in a Veteran's Administration Hospital, or which in the absence of insurance, would have been furnished without cost, or which are furnished under conditions which the Eligible Individual has no legal obligation to pay;

21. Charges incurred by an Eligible Dependent Child once that individual has received Plan benefits totaling the individual's orthodontic lifetime maximum benefit, as specified in this Dental Benefits Section;

22. Charges incurred by an individual for which payments are due to the orthodontist before the individual's effective date of benefits;

23. Charges incurred by an individual for which payments are due to the orthodontist after the individual's eligibility for benefits under this Plan terminate;
24. Charges incurred for any treatments, care, services or supplies which are in excess of any limitation specified in this entire Plan, or which are specified as not payable;

25. Charges incurred for general anesthesia (including anesthetists' fees and related facility charges), where the anesthesia is: (a) administered at a Hospital in connection with a dental service or dental procedure (regardless of whether the dental service or dental procedure itself is covered under any part of the Plan); and (b) not administered in connection with oral or dental surgery; and

26. 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.

Alternate Courses of Dental or Orthodontic Treatment

If there are two or more alternative methods of treating a particular dental condition, the amount of charges considered to be Covered Dental Expenses or Covered Orthodontia Expenses will be determined as follows:

- If alternative services may be used to treat a dental or orthodontic condition, Covered Dental Expenses or Covered Orthodontia Expenses will be limited to the Reasonable and Customary Charge for that service which:

  - Is most commonly used nationwide in the treatment of such condition; and

  - Is recognized by the Dental profession to be appropriate in accordance with the accepted nationwide standards of dental and orthodontic practice.

- If an Eligible Individual or an Eligible Individual's Dentist chooses an alternate course of treatment which is a more expensive level of care than the Reasonable and Customary level of care (as determined by the provisions above) any charges in excess of such level will not be considered Covered Dental Expenses or Covered Orthodontia Expenses.

VISION CARE PLAN

The Plan provides for the basic visual needs of you and your Eligible Dependents through Vision Service Plan (VSP). By choosing a VSP doctor, you can receive the following benefits at little or no charge to you.

- Eye Exams
- Single-Vision Eyeglasses (Lenses and Frames)
- Bifocal Eyeglasses (Lenses and Frames)
- Trifocal Eyeglasses (Lenses and-Frames)

You are free to choose a doctor who is not a VSP doctor. The Plan will still provide vision coverage, but lower, out-of-network benefits apply, and you will need to submit your own claims for reimbursement. No matter which doctor you see, identify yourself as a VSP plan Eligible Individual.

*Eye exams and testing that are primarily for the purpose of diagnosis and treatment of medical conditions, such as glaucoma, are covered under the Plan's medical benefits, not the Plan's vision benefits.

If you have questions about the Vision Care Plan, please call VSP at 1-800-877-7195 or visit www.vsp.com or call the Fund Office.

Schedule of Vision Care Benefits

Frequency Exam/Lenses/Frame for adults 18 years of age and older	12/24/24
Frequency Exam/Lenses/Frame for children up to 18 years of age	12/12/12
Copayments – Exam/Materials	$10 Exam/$20 Materials
VSP Participating Provider	
Exam	Covered in Full
Contact Lens Exam	15% off professional services Standard and premium fit covered in full after copayment, which is not to exceed $60
Covered Lenses	Single Vision, Bifocal or Standard Progressive, Trifocal, and Lenticular (Polycarbonate impact-resistant lenses covered) UV and Scratch Coatings are covered only when in-network
Frame Allowance	Retail: $300

	Wholesale: $70 Featured: $200 Costco: $100
Contact Lens Allowance Material copay does not apply.	$300
Lens Options	Cost-controlled pricing in which members save an average 35-40%
Non-Participating Provider	
Examination	Covered up to $77
Single Vision Lenses	Covered up to $75
Bifocal or Standard Progressive Lenses	Covered up to $100
Trifocal Lenses	Covered up to $130
Lenticular Lenses	Covered up to $154
Frame	Covered up to $118
Elective Contact Lens Allowance	Covered up to $165

Vision Care Benefit Details

The Vision Care Plan is not part of the Plan's major medical benefit but instead is a separate benefit. So, amounts you pay for vision care do not help you to satisfy the major medical deductible and are not limited by the major medical out-of-pocket expense limit.

Who is Eligible for the Vision Care Plan

You and your Eligible Dependents are eligible for vision benefits if you meet the eligibility requirements for the Plan's Medical Expense Benefit.

If an Eligible Individual goes from Employee to Dependent status, or goes from Dependent to Employee status, Vision Benefits paid for charges incurred while such individual was in the previous status will be used in determining such individual's remaining Vision Expense Benefit Two Calendar Year Maximum Benefit.

Covered Expenses

- Covered expenses are charges incurred for the services of Ophthalmologists (M.D.), or if the Eligible Individual has previously had corrective glasses or contact lenses, charges incurred for the services of a licensed optician.

- Complete vision examination and related expenses.

- Prescription lens and frames,

The lens allowances are for two lenses, if only one lens is needed, the allowance will be ½ of the paid allowance.

Covered Vision Expenses are the actual Medically Necessary Reasonable and Customary Charges incurred by the Eligible Individual for the services provided.

Contact Lenses

Elective or Medically-Necessary contact lenses may be chosen *instead* of glasses.

Elective Contact Lenses. The standard eye exam is covered in full from a VSP doctor. The allowance specified on the Schedule of Vision Care Benefits will be provided toward the contact lens evaluation exam, fitting costs, and materials when using either a VSP doctor or an out-of-network provider. Any costs exceeding the allowance are your responsibility.

Medically-Necessary Contact Lenses. Medically-Necessary contact lenses are covered in full when you obtain them from a VSP doctor. If you choose an out-of-network provider, your benefit is reimbursed up to the amount specified on the Schedule of Vision Care Benefits (excluding exam). Medically-Necessary contact lenses are covered for one of the following conditions:

- Following cataract surgery;
- To correct extreme visual acuity problems that cannot be corrected with spectacle lenses;
- 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 cosmetic reasons. The following items are cost-controlled by VSP, and there will be an extra charge for them:

- Blended lenses;
- Contact lenses (except as noted above);
- Oversize lenses;
- Progressive multifocal lenses;
- Photochromic or tinted lenses other than Pink 1 or 2;
- Coated or laminated lenses (except for scratch coating and UV coating);
- Frames that cost more than the Plan allows;
- Certain limitations on low vision care;
- Cosmetic lenses; and
- Optional cosmetic processes.

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.

There is **no benefit available under this Vision Care plan** for professional services or material connected with:

- Orthoptics or vision training and any associated supplemental testing;
- Plain lenses (non-prescription);

- Two complete pairs of glasses in lieu of bifocals;
- Replacement of lenses and frames furnished under this Plan which are lost or broken. Lenses and frames will not be replaced except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Any eye exam, or any corrective eyewear, required by an employer as a condition of employment;
- Subnormal vision aids;
- Any vision charge that is greater than the maximum benefit;
- More than one set of frames or lenses every two Calendar Years for adults of 18 years of age or older except for a second pair of Medically Necessary contact lenses or prescription glasses during any consecutive twenty-four month period in excess of the biannual maximum;
- Sunglasses or goggles, plain or prescription;
- Safety glasses for Dependents;
- Procedures and supplies furnished due to a visual defect which is related to any occupation for wage or profit;
- Services or supplies received due to declared or undeclared war, or any act of war, or military or naval service of any country except as covered under TRICARE;
- Vision care services or supplies received from a medical department maintained by any employer, mutual benefit association, labor union, trustee or other similar group;
- Services or supplies an Eligible Individual is not required to pay; and
- Any service or material provided by any other vision care plan or group benefit plan providing benefits for vision care.

If you'd like further information regarding VSP doctors or to request a benefit form, please contact VSP.

Safety Eyewear Program

If you have questions about the Safety Eyewear Program, please call the Fund Office.

Eligibility for Benefits

Commercial, residential, inside construction, maintenance, and Limited Energy Agreement Bargaining Unit Employees are eligible for this benefit. Non-bargaining Unit Employees, Dependents or Retirees are not eligible for this benefit.

Amount of Benefits Paid

You can have a pair of prescription safety glasses made for you every twenty-four (24) months under this program. The Plan provides you sixty dollars ($125) toward safety eyewear if purchased through a participating provider. You must pay the difference for more expensive frames or lenses. To receive this benefit, contact the Fund Office for a claim form and a participating provider list.

LOSS OF TIME BENEFITS (DISABILITY BENEFITS)

If you have questions about the Loss of Time Benefits available under the Plan, please call the Fund Office.

Eligibility for Benefits

To be eligible for weekly income benefits, an Eligible Employee must meet all of the following requirements:

- You must be Totally Disabled as a result of non-occupational Injury or Sickness and be completely unable to perform each and every duty of your occupation or employment.
- You must be Covered under the medical and loss of time portions of the Plan on the date your Total Disability begins.
- You must be under the care of a Physician of medicine for the Total Disability.
- You must have used all accrued benefits for sick leave.
- You must not be receiving salary, wages or unemployment compensation.

In the case of work-related Total Disability, to receive pension and/or health care Credits, the Fund Office also *must* receive a First Report of Injury (i.e., a doctor's determination of disability) and proof of your Worker's Compensation payments. In addition, to receive any loss of time benefits under this Plan, you must have used up all other loss of time benefits and/or disability benefits provided through your Employer (this includes compensation for loss of time such as salary continuation, sick leave and/or short-term disability benefits).

If an Eligible Employee becomes continuously Totally Disabled as the result of an occupational Illness or Injury incurred while working in a non-covered position which has a lower wage rate then provided by the Plan, the benefit to be paid will be the difference between the Plan's regular loss of time benefit amount and the benefit amount payable to the Eligible Employee by the Workers' Compensation carrier for the Eligible Employees. Benefits will be determined as though Workers' Compensation coverage was in place, even if none was, if the Eligible Employee could have been covered. The requirement that an Eligible Employee must be Totally Disabled as a result of non-occupational Injury and/or Sickness and so be unable to perform each and every duty of the individuals occupation in order to receive Weekly Income Benefits will not act to limit this benefit. Such benefit will only be provided to Eligible Employees who were actively employed by a Contributing Employer on the date of the Illness or Injury, or were available for work ("on the book") and have not refused more than two consecutive calls for work.

Schedule of Loss of Time Benefits

Weekly benefits are payable up to fifty-two (52) weeks per occurrence of Total Disability. Extensions of disability benefits beyond thirteen (13) weeks must be in writing and subject to the approval of the Board of Trustees, including, at the Trustees' discretion, examination of the Eligible Employee by a Physician of the Plan's choice. For continued disability payments, you

will be required to provide proof of application to Social Security at twenty-six (26) weeks and every six (6) months thereafter. If you do not provide this proof, disability payments will cease. This benefit is subject to a fifty-two (52) week cap per occurrence of Total Disability and a lifetime maximum of one hundred four (104) weeks. If you sustain an additional Injury while collecting disability benefits the maximum benefit aggregate period for which you may receive loss of time benefits is fifty-two (52) weeks.

The amount of your weekly benefit is based on the cause of your Total Disability as shown below:

Work-Related Injury or Sickness

Disability Period	Maximum Rate
Second and Third Days of First Week	Reimbursed at the current Minnesota unemployment weekly rate provided the second and third days are not paid under Workers' Compensation

Non-Occupational Injury or Sickness

Disability Period	Waiting Period Before Benefits Will Be Paid	Maximum Rate
Weeks 1 Through 6	7 Days (If Confined to a Hospital overnight because of Illness – None)	Paid at the Lesser of: 65% of the Eligible Employee's or Apprentice's actual weekly wage based on a 40-hour workweek, *or* 65% of current average journeyman wireman's weekly wage.
Weeks 7 Through 52	None	Paid at 100% of the current effective Minnesota unemployment compensation weekly rate for the Eligible Employee.

Reduction for Social Security Benefits

Loss of time benefits from the Plan will be reduced if the Eligible Employee receives disability benefits from the Social Security Administration while receiving loss of time benefits. That means if the award from Social Security is equal to or exceeds the benefits otherwise payable under the Plan, the Eligible Employee will not be entitled to weekly loss of time benefits under this Plan. In addition, if an Eligible Employee receives an award from the Social Security Administration for a period of time during which you had already received weekly loss of time benefits, the Eligible Employee will be required to refund to the Plan an amount equal to the lesser of:

- The amount of loss of time benefits you received under this Plan during that time; or
- The amount of Social Security disability benefits you received during that time.

For example, imagine Joe applies for Social Security disability benefits in January. He is already receiving loss of time benefits from the Plan in the amount of $325 a week. The Social

Security Administration approves benefits for him in the amount of $100 a week on June 1, and backdates this award to January 1 (22 weeks), or $2,200. Since Joe received $2,200 from the Social Security Administration, and it is less than the amount paid by the Plan ($325 a week for 22 weeks, or $7,150), he must repay the Plan $2,200.

The Fund will apply any amount an Eligible Employee is required to refund against future benefits payable under this Plan.

Reduction for Wage Loss Coverage

Loss of time benefits from the Plan will be reduced if the Eligible Employee receives benefits from any wage loss coverage that may be provided through an automobile policy, Motor Vehicle policy, homeowner's policy, premises insurance policy, or any other type of insurance coverage that provides benefits for the loss of wages. That means if the loss of wages benefits received are equal to or exceed the loss of time benefits otherwise payable under the Plan, the Eligible Employee will not be entitled to weekly loss of time benefits under this Plan.

The Plan may require that an Eligible Individual show that he or she has made a reasonable effort to find out if there is another applicable insurance policy before loss of time benefits will be paid by the Plan. Wage loss benefits that might otherwise be payable under another insurance policy will not be paid by the Plan merely because the Eligible Individual has not made a claim under the other insurance policy.

Reduction for Pension Benefits

Loss of time benefits from the Plan will be reduced if the Eligible Employee has commenced benefits under the provisions of a pension plan negotiated or sponsored by the I.B.E.W while receiving loss of time benefits. That means if the pension benefits received are equal to or exceed the loss of time benefits otherwise payable under the Plan, the Eligible Employee will not be entitled to weekly loss of time benefits under this Plan.

When Benefits Begin

Weekly disability benefits for a non-occupational Injury or Illness will begin:

- On the eighth (8^{th}) day of Total Disability due to an Injury;
- On the eighth (8^{th}) day for a Total Disability due to Sickness when not hospitalized; or
- On the first day if hospitalized due to Sickness or Injury before the eighth (8^{th}) day of Sickness or Injury.

For Total Disability due to occupational Injury or Sickness, benefits will begin effective on the second (2^{nd}) day of Total Disability after the Plan receives notification of Workers' Compensation approval.

Filing a Claim for Benefits

To file a claim for loss of time benefits, have your Employer and Physician complete their sections of the Weekly Income Claim Form and return the form to the Fund Office:

IBEW 292 Benefits
6900 Wedgwood Road North, Suite 425
Maple Grove, MN 55311

When you file a claim for benefits, be sure to follow the proper claim filing procedures explained in this handbook. If you send a claim to the Fund Office, 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 additional information to the Fund Office.

Your application for loss of time benefits must be submitted to the Fund Office in the format designated by the Trustees within ninety (90) days of your first day of Total Disability. Approval or denial of a claim will usually be made within ninety (90) days after all necessary information is received. You will be notified if more time (up to an additional ninety (90) days) is needed.

Successive and Simultaneous Periods of Total Disability

When you have two or more periods of Total Disability for the same or a related cause, they will be considered as one period of disability unless the second period of Total Disability starts after you have returned to work for two (2) months or more. If the periods are considered to be one period, the second period of Total Disability would be considered a continuation of the first one for benefit purposes. No waiting period is required. Weekly loss of time benefits would begin on the first day you are unable to work.

Successive periods of Total Disability separated by less than two (2) calendar months of work will be considered one period of disability unless the second Total Disability is due to a non-occupational Injury or Sickness entirely unrelated to the causes of the previous Total Disability and begin after you have returned to full-time work for at least ten (10) consecutive full work days.

If you simultaneously have two or more Injuries or Sicknesses that result in Total Disability while receiving Plan benefits, the benefits payable will be limited to a maximum of seventy-two (72) weeks. If during a period of Total Disability, while receiving Plan Benefits, you experience an Injury or Sickness that results in Total Disability the benefits payable will be limited to a combined aggregate maximum of seventy-two (72) weeks.

Maternity Benefits

If a female Eligible Employee is Disabled due to pregnancy or a pregnancy-related condition, that time will be considered as a disability due to Sickness.

Limitations and Exclusions

No weekly loss of time income benefits will be paid for any Total Disability which results:

- From a Sickness or Injury for which you are not under the direct care of an M.D.;

- From an Injury that occurred during any type of occupation or employment for profit;

- During any period for which you receive Retiree benefits;

- From any Injury or Sickness for which you are, or may be, entitled to receive benefits in whole or in part under any Worker's Compensation law, Occupational Diseases law, Employer's Liability law or similar law, unless you have signed a subrogation agreement and agreed to pursue a claim under the relevant law (and even then not in excess of the loss of time rate that would be payable to you under that law if your Injury or Sickness were determined to be work-related);

  Note: Upon a final judicial adjudication that your Injury or Sickness is **not** work-related, the Plan will pay you the difference of the loss of time benefit that would have been payable under the Plan for the period ending on the date of that adjudication had the Plan considered the Sickness or Injury to be not work-related since the beginning of the disability period over the loss of time benefit previously paid under the Plan for that Sickness or Injury for the period ending on the date of that adjudication; or

- For periods of time during which you receive salary, wages or unemployment compensation, except that if you were receiving loss of time benefits under the Plan immediately before returning to part-time Covered Employment, loss of time benefits payable under the Plan but for receipt of salary or wages for that part-time work will be payable in the reciprocal percentage that you are working (for example, at 70% if you are working 30% of a full-time schedule).

Special Note: You must use all accrued salary continuation or sick leave benefits before you are eligible for weekly loss of time benefits.

Taxation of Weekly Income Benefits

You must include your weekly loss of time benefits in your gross income and pay federal income tax on them.

Weekly income benefits are also subject to Social Security taxes (FICA). You pay half of the tax, and your employer pays the other half. According to federal law, the Plan will withhold your share of the FICA tax from each weekly benefit check paid to you and send it to the government.

You should contact a competent tax advisor or attorney if you have any questions regarding taxes on your weekly income benefits.

Indemnity Limits and Benefit Provisions

- Benefits will be payable in an amount not to exceed the weekly Maximum Benefit specified on the Schedule of Benefits.

- Benefits will be payable for up to but not to exceed the maximum indemnity period of seventy-two (72) weeks during any one period of disability.

- Benefits are payable on the basis of a seven (7) day week.

- Benefits will be paid on the first (1st) and fifteenth (15th) day of each calendar month.

- If benefits are due an Eligible Employee for a fractional part of a week, the Eligible Employee will receive one-seventh of the weekly benefit for each day of Total Disability.

- A disability will not be considered to have begun until the first day the Eligible Employee is actually examined or treated by a Physician for the Injury or Sickness causing such Total Disability.

- The Plan may assign any disability claim to a case manager for review and management. The case manager may determine that benefits should be paid, suspended, or discontinued, and may place conditions on an Eligible Individual's receipt of benefits. By accepting weekly loss of time, the Eligible Individual agrees to cooperate fully with the Plan's case manager and to abide by the case manager's decisions regarding the Eligible Individual's claim for benefits.

Repayment of Loss of Time Benefits (Non-Bargaining Unit Employees)

Non-Bargaining Unit Employees as defined on page 5 of the Benefit Eligibility Section must pay back to the Plan any Loss of Time Benefits received if one of the following events occurs:

- The Non-Bargaining Unit Employee does not return to work; or

- The Non-Bargaining Unit Employee returns to work, but voluntarily terminates their coverage under the Plan within six months of returning to work.

MATERNITY LEAVE BENEFITS

If you have questions about the Maternity Leave Benefits available under the Plan, please call the Fund Office.

Pre-Delivery Health and Safety Leave and Post-Delivery Recovery Leave

Effective July 29, 2021, the Plan makes available pre-delivery health and safety leave and post-delivery recovery maternity leave (collectively "Maternity Leave Benefits") to pregnant female Eligible Employees who are Bargaining Unit Employees performing Covered Employment ("Leave Eligible Employees") and who satisfy all of the requirements of this section. Non-Bargaining Unit Employees, Dependents, or Retirees are not eligible for this benefit.

A. Pre-Delivery Health and Safety Leave Benefit.

The Plan makes pre-delivery non-intermittent health and safety leave available to pregnant Leave Eligible Employees beginning with the twenty-eighth (28th) week of gestation who satisfy all of the requirements below.

1. Your treating Physician must complete the Certification of Physician form designated by Plan certifying that you are not able to perform Covered Employment due to physical or mental limitations arising from your pregnancy and/or your work environment which jeopardize the health and/or safety of you and/or your fetus. Your request to the Plan for Pre-Delivery Health and Safety Leave Benefits must include a completed Certification of Physician dated within fifteen (15) days of the date you submit your request for Pre-Delivery Health and Safety Leave Benefits and/ or the date of a subsequent request by the Plan.

2. You must be, or have been, a Leave Eligible Employee in the calendar month in which you:

    a. Apply for Pre-Delivery Health and Safety Leave Benefits; or

    b. Began receiving Loss of Time benefits under the Plan which you continued to receive through the twenty-seventh (27th) week of gestation.

3. You have not received Maternity Leave Benefits under this Plan for more than fifty (50) weeks, in aggregate, during your lifetime. Each week, or partial week, for which you receive Pre-Delivery Health and Safety Leave Benefits and/or Post-Delivery Recovery Leave Benefits counts towards your fifty (50)-week maximum lifetime Maternity Leave Benefit period.

4 The Plan will not provide Pre-Delivery Health and Safety Leave Benefits on an intermittent basis.

5. Termination of your Pre-Delivery Health and Safety Leave Benefits due to your receipt of Loss of Time Benefits under the Plan will not impact your eligibility for Post-Delivery Recovery Leave Benefits if you otherwise meet the requirements provided in subsection B below.

B. Post-Delivery Recovery Leave Benefit.

The Plan provides a non-intermittent post-delivery recovery leave benefit to Leave Eligible Employees who satisfy all of the requirements below. A Leave Eligible Employee who delivers a Child at, or after, twenty-four (24) weeks of gestation is eligible for up to six (6) weeks of Post-Delivery Recovery Leave Benefits beginning immediately following a vaginal delivery, or up to eight (8) weeks immediately following a cesarean delivery.

1. Your delivery must occur on or after the beginning of the twenty-fourth (24th) week of gestation

2. You must provide a copy of the certificate of birth required by the state in which you delivered.

3. You must be, or have been, a Leave Eligible Employee in the calendar month in which you:

   a. Apply for Post-Delivery Leave; or

   b. Began receiving Loss of Time benefits under the Plan which you continued to receive up to the date of delivery.

4. You have not received Pre-Delivery Health and Safety Leave Benefits and/or Post-Delivery Recovery Leave Benefits under this Plan for more than fifty (50) weeks in aggregate during your lifetime. Each week, or partial week, for which you receive Pre-Delivery Health and Safety Leave Benefits and/or Post-Delivery Recovery Leave Benefits counts towards your fifty (50)-week aggregate maximum lifetime Maternity Leave Benefit period under the Plan.

5. Your eligibility to receive Post-Delivery Recovery Benefits is not dependent on whether you received Pre-Delivery Health and Safety Leave Benefits if you otherwise meet the requirement provided in this subsection B.

6. Termination of your Pre-Delivery Health and Safety Leave Benefit due to your receipt of Loss of Time benefits under the Plan will not impact your eligibility for the Post-Delivery Recovery Leave Benefit if you otherwise meet the requirement provided in this subsection B.

7. Post-Delivery Recovery Leave Benefits are not available on an intermittent basis.

Wage Replacement

During your Pre-Delivery Health and Safety Leave and/or Post-Delivery Recovery Leave the Plan will pay you a weekly wage replacement amount equal to the **lesser** of:

A. One-hundred percent (100%) of the hourly wage rate for the Covered Employment classification applicable to you pursuant to the Collective Bargaining Agreement under which you are covered on the date that you begin receiving Maternity Leave Benefits multiplied by forty (40) hours per week; or

B. One-hundred percent (100%) of the hourly wage rate applicable to Journeymen pursuant to the Collective Bargaining Agreement under which you are covered on the date that you begin receiving Maternity Leave Benefits multiplied by forty (40) hours per week.

1. If you are eligible for Maternity Leave Benefits for less than a full calendar week, your wage replacement amount for that week will be calculated at the rate of one-seventh (1/7th) of your total weekly wage replacement payable under this section for each day that you are entitled to wage replacement under this section.

2. The Plan will pay your weekly wage replacement to you on the first (1st) and fifteenth (15th) days of each calendar month.

Maintenance of Plan Eligibility

A. The Plan will credit you with the Plan Contributions required of your Employer on your behalf pursuant to the Collective Bargaining Agreement under which you are covered based on a forty (40)-hour week for the duration of time of your Pre-Delivery Health and Safety Leave and/or Post-Delivery Recovery Leave for which you received wage replacement under this Maternity Leave Benefit.

B. If you are eligible for Maternity Leave Benefits for less than a full calendar week, the amount credited by the Plan on your behalf for that week will be calculated at the rate of one-seventh (1/7th) of your total weekly Plan Contributions required under this subsection for each day during that week that you are entitled to Plan credits under this subsection.

C. You must timely remit your portion of the monthly premium, if applicable, to maintain coverage under the Plan.

Electrical Workers Local No. 292 Pension Plan ("Pension Plan")

A. You will be credited with Pension Plan hours, based on a forty (40)-hour week, for the period that you are away from work for Pre-Delivery Health and Safety Leave and/or Post-Delivery Recovery Leave and you received wage replacement under this section if the Collective Bargaining Agreement under which you are covered requires Employer contributions to the Pension Plan.

B. If you are eligible for Maternity Leave Benefits for less than a full calendar week, your pension hours credited for that week will be calculated at the rate of one-seventh (1/7th) of your total weekly Pension Plan hours required under this section for each day during that week that you are entitled to Pension Plan accruals under this section.

Coordination with Other Wage Replacement Payments

A. If you are entitled to any other weekly disability benefits, loss-of-time benefits, unemployment benefits, workmen's compensation benefits, or any other source of wage replacement payments from the Plan, your Employer, the Union, or government-provided benefits (federal, state or local), or any other source, for any period of time during which you are/were also receiving wage replacement payments under this Maternity Leave Benefit, the amount of your weekly wage replacement payments under this Maternity Leave Benefit will be reduced such that the sum of your weekly wage replacement payment under this Maternity Leave Benefit, plus any other disability, loss-of-time benefits, unemployment benefits, workmen's compensation benefits, or any other source of wage

replacement does not exceed the total wage replacement amount calculated under the wage replacement section of this Maternity Leave Benefit.

B. You will not be entitled to a wage replacement payment under this Maternity Leave Benefit if the sum of any other weekly disability benefits, loss-of-time benefits, unemployment benefits, workmen's compensation benefits, or any other source of wage replacement benefits that you receive from the Plan, your Employer, the Union, government-provided benefits (federal, state or local), or any other source equals or exceeds the maximum wage replacement benefit for which you are/were eligible under the Wage Replacement section of this Maternity Leave Benefit during that same period.

C. You have an affirmative obligation to immediately notify the Plan in writing if you become eligible for, or receive, any other wage replacement payments from any source for any period that you are or were receiving wage replacement payments under this Maternity Leave Benefit.

Termination of Maternity Leave Benefits

Your Maternity Leave Benefits will terminate, even if you are unable to return to work, upon the earliest occurrence of any of the following events:

A. You have received an aggregate total of fifty (50) weeks of Maternity Leave Benefits;

B. Your Physician releases you to resume work;

C. You become eligible for Loss of Time Benefits; or

D. You are no longer eligible to receive Maternity Leave Benefits under the terms of the Plan.

Miscellaneous

A. The period for which you are eligible for Maternity Leave Benefits will run concurrently with any FMLA leave or similar leave for which you are eligible pursuant to state or federal law.

B. The Plan intends to administer Maternity Leave Benefits in full compliance with applicable law. The applicable federal, state or local law, including, but not limited to, the Pregnancy Discrimination Act, will govern if a situation arises in which the Plan's administration of its Maternity Leave Benefits conflicts with applicable law.

C. You cannot receive Maternity Leave Benefits for any period of time for which you draw Supplemental Disability and Workers Compensation Benefits from the Electrical Workers Local No. 292 Supplemental Unemployment Benefit Plan.

ACCIDENTAL DISMEMBERMENT BENEFITS

Schedule of Accidental Dismemberment Benefits

An accidental dismemberment benefit is available to you while an Eligible Employee and Covered Under the Plan. The "Principal Sum" of the benefit is $10,000.

The amount of benefits paid is listed below:

For Loss Of:	The Benefit Is:
Life	The Principal Sum
Two Hands	The Principal Sum
Two Feet	The Principal Sum
One Hand and One Foot	The Principal Sum
Sight of Two Eyes	The Principal Sum
One Hand and Sight of One Eye	The Principal Sum
One Foot and Sight of One Eye	The Principal Sum
One Hand or One Foot	One-Half The Principal Sum
Sight of One Eye	One-Half The Principal Sum

Payment of Benefits

Benefits are paid to the Eligible Member/Employee in a lump sum after the Fund Office receives a medical report explaining the loss of limb or sight that occurred while Covered Under the Plan, regardless of whether the Injury occurred during the course of employment. The loss must occur within 90 days of the Injury and must be a result of an Injury.

Benefits will be paid only for the greatest of the losses indicated if more than one loss is sustained as the result of any one Injury or occurrence.

Filing a Claim for Benefits

An Eligible Employee must complete the necessary claim form and return it with any requested proof of loss to the Fund Office:

IBEW 292 Benefits
6900 Wedgwood Road North, Suite 425
Maple Grove, MN 55311

Be sure to follow the proper claim filing procedures explained in this handbook. If an Eligible Employee sends a claim to the Fund Office and it cannot be processed because information is missing, the Eligible Employee will receive a notice stating why the claim cannot be completed and what additional information is needed. It is the responsibility of the Eligible Employee to send this additional information to the Fund Office.

Approval or denial of a claim will usually be made within 90 days after all necessary information is received. You will be notified if more time (up to an additional 90 days) is needed.

Notice and Proof of Claim and Claim Filing Deadline

Accidental Death and Dismemberment claims must be submitted to the Fund Office within ninety (90) days of the end of the date the Injury occurred, unless the Eligible Employee can show it was not reasonably possible to do so. The claim must include sufficient personal information, a description of the Injury, and any itemized bills for treatment or other required forms that help to provide proof of your Injury. In no event will benefits will be paid for claims submitted to the Fund Office more than one hundred eighty (180) days after the date the Injury occurred.

Exclusions

Benefits will not be paid for any loss that is caused directly or indirectly, or in whole or in part, by any of the following:

- Service in the armed forces of any country while such country is engaged in war;
- Declared or undeclared war, any act of war, or insurrection;
- Medical or surgical treatment of an Illness or disease;
- Participation in, or the result of participation in, the commission of a felony, or a riot, or a civil commotion;
- Travel or flight as a pilot or crew member in any kind of aircraft including, but not limited to a glider, a seaplane, or a hang kite;
- Ptomaine or bacterial infections except infections caused by pyogenic organisms which occur with and through an accidental wound or cut;
- Loss due to an Injury to a Dependent;
- Suicide or attempted suicide while sane or insane, except when caused by or resulting from a physical or mental condition of the Eligible Employee; or
- Bodily or mental Illness or disease of any kind.

Termination of Coverage

Dismemberment benefits will terminate on the earliest of the following dates:

- Survivor benefits have terminated;
- The Employee retires or otherwise ends employment; or
- The Employee ceases active work on a full-time basis.

LIFE INSURANCE BENEFITS

The Plan offers a fully-insured life insurance benefit governed by an insurance policy through The Union Labor Life Insurance Company. The provisions of this section are a summary of key provisions of the Union Labor Life Insurance Company policy. If there is any conflict between this Section and the insurance policy, the insurance policy will govern except for the definition of Eligible Dependent Child.

If you have questions about the Life Insurance Benefits under the Plan or wish to review the Ullico Life policy, contact the Fund Office.

Schedule of Life Insurance Benefits

The Plan offers Eligible Employees and their Eligible Dependents life insurance benefits. No life insurance coverage whatsoever is available, however, once you retire or are no longer eligible for Plan benefits, except as provided in the section entitled "Continuance of Life Insurance and Conversion", below.

	Benefit
Employee/Member Life Insurance Benefit	
Employee/Member	$20,000

Dependent Life Insurance Benefit	
A life insurance benefit is also available for your Spouse and Eligible Child(ren) in the event of their deaths.	
Spouse	$5,000
Each Eligible Dependent Child Ages 14 days to 26th Birthday	$5,000

The death benefit will be paid to the Beneficiary after presentation of the death certificate of the Eligible Employee or Eligible Dependent to the Fund Office.

Schedule of Reductions at Age 65 or Older

If you reach age 65, are still eligible for life insurance benefits under the Plan and have not retired, life insurance benefits will be reduced as follows:

If you are Age . . .	**Life Insurance Benefit will Reduce to . . .**
65	65% of your total amount of benefit
70	45% of your total amount of benefit
75	30% of your total amount of benefit
80	20% of your total amount of benefit
85	15% of your total amount of benefit
90	10% of your total amount of benefit
Benefit reductions will be made on the first day of the policy month which coincides with or follows the day the insured attains the specified age. If you are age 65 or older on the day the insured becomes insured under the policy, the reduction will be made to conform with the insured's attained age. Life insurance benefits end on the date of your retirement.	

Following are two examples to help explain the reduction:

Amount of Insurance Before Turning 65 or Older	Your New Age	Factor	Calculation	=	New Benefit
$20,000	65	.65	$20,000 x .65	=	$13,000
$20,000	70	.45	$20,000 x .45	=	$9,000

Dependent Life Insurance Benefit

A life insurance benefit is also available for Eligible Spouse and Eligible Child of an Eligible Employee in the event of their deaths. The benefits are specified on the Schedule of Life Insurance Benefits and are available if an Eligible Spouse dies before the Eligible Employee or an Eligible Dependent Child from age 14 days to up to the 26th birthday dies before the Eligible Employee.

Beneficiary

- If you do not name a Beneficiary, the benefit is paid in the following order:
  - Surviving Spouse of the Eligible Employee; if none, then
  - Your surviving Children (natural and/or legally-adopted Children); in equal shares; if none, then
  - Your surviving parents; in equal shares; if none, then
  - Your surviving brothers and sisters; in equal shares; if none, then
  - To your estate.

Living Benefits Option

If you or any Eligible Dependent has a terminal condition while insured under the Plan and the Insurance policy, you or your Eligible Dependent may request living benefits while living. The amount of and the conditions to apply for living benefits are governed by the MII Life Insurance policy, contact the Fund Office.

Payment of Life Insurance Benefits

The following documents must be sent to the Fund Office to ensure payment of Life Insurance benefits upon the death of an Eligible Employee/or Eligible Dependent:

- A certified death certificate; and
- The Social Security number, date of birth and address of the beneficiary.

EMPLOYEE ASSISTANCE BENEFIT

T.E.A.M. Employee Assistance Program

Call T.E.A.M. at (651) 642-0182 or 1-800-634-7710 for help or for answers to questions about this benefit.

Confidential Assessment, Counseling, and Referral Services

The T.E.A.M. Employee Assistance Program (EAP) is a confidential assessment, counseling and referral service for you and your family to help resolve personal problems. The T.E.A.M. program provides benefits outside of the Plan.

Skilled counselors are available 24 hours a day to talk with Eligible Individuals in confidence about problems. A T.E.A.M. counselor can help assist with:

- Family and Marriage problems;
- Alcohol or Controlled Substance Dependency;
- Financial Concerns;
- Emotional Problems;
- Legal Referrals; and
- Work-Related Problems.

For example, a T.E.A.M. counselor can help an Eligible Individual to:

- Learn better coping skills in everyday life;
- Identify depression in him or herself or a loved one;
- Find a way to intervene with a chemically dependent person in his or her family;
- Assess marriage problems;
- Find a financial counselor to help develop a budget; or
- Teach communication skills.

Some problems can be resolved with a counselor in just a few minutes over the telephone. Or an Eligible Individual may choose to schedule a meeting with a counselor from T.E.A.M.

At the first meeting, the counselor will discuss problems of the Eligible Individual and determine the type of assistance needed. More meetings with the same counselor can be scheduled. Or if the Eligible Individual and the counselor decide that long-term counseling or treatment is needed, a referral to the appropriate agency will be made.

The counselor will follow up with the Eligible Individual to make sure that he or she was satisfied with the service received and that the problem is being resolved.

The assessment, short-term counseling and referral services are paid by the Plan. If an Eligible Individual is referred for long-term counseling or treatment, the Plan may or may not cover some of these costs. The T.E.A.M. counselor will consider Eligible Individual's benefits situation when suggesting a referral.

Please call the Fund Office for additional information on T.E.A.M. or call them directly.

ADOPTION ASSISTANCE BENEFIT

Rules Governing the Adoption Assistance Benefit

An Eligible Employee can be reimbursed for adoption expenses (as defined below) up to $1,500 for each child the Eligible Employee legally adopts and becomes a Dependent (as defined by the Plan) of the Eligible Employee while Covered Under the Plan.

Included as legitimate adoption expenses are fees and expenses paid to third parties and reasonably incurred in the adoption process and will include:

- Adoption Agency Fees;
- Legal Fees;
- Transportation Costs;
- Medical Expenses;
- Other Reasonable Adoption Process Expenses; and
- Expenses for temporary foster care with persons other than the adoptive parents.

This benefit *excludes* the adoption of stepchildren and other intra-familial adoptions. For instance, a benefit would not be payable if a grandparent adopts his or her grandchild.

Filing an Adoption Assistance Claim

Claims for adoption assistance benefits must be accompanied by a valid final decree of adoption issued while the Eligible Employee is Covered Under the Plan. The Plan may require other written documentation -- e.g., proof that the adoption expenses were incurred -- before benefits will be paid.

Payment of an Adoption Assistance Benefit

Adoption assistance benefits are not subject to deductible and copayment provisions of the Plan. If you have any questions on adoption assistance benefits, please contact the Fund Office.

LIMITATIONS AND EXCLUSIONS

Please read this section carefully. The Plan will not pay for any of the charges, expenses or services described in this Section, and the amount of any such incurred charges will be deducted from an Eligible Individual's allowable expenses before the benefits of this Plan are determined.

1. Any expense due to an Injury, Sickness, condition, disease or Mental or Nervous Disorder sustained while the individual was performing any act of employment or doing anything related to any occupation or employment.

2. Charges for treatment, care, services, supplies or procedures provided while a person is confined in a hospital operated by the U.S. Government or its agency, provided, however, that if such charges are made by a Veterans Administration (V.A.) hospital which claims reimbursement for the "reasonable cost" of care for a non-service related disability, such charges will be considered Covered Medical Expenses to the extent required by law and to the extent that they would have been considered Covered Medical Expenses had the V.A. not been involved.

3. Charges incurred by an Eligible Individual for which the Eligible Individual is not legally required to pay.

4. Education, training, or room and board while a person is confined in an institution which is primarily a school or institution of learning or training.

5. Any charge while a person 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 Plan's definition of a "Skilled Nursing Facility" and the charges are incurred in accordance with the Plan provisions governing Skilled Nursing Facility care).

6. Any type of custodial care, which is care designed primarily to assist an individual to meet the activities of daily living except as may be payable under the Plan provisions governing Hospice care benefits.

7. A physical examination which is given primarily: (a) to determine whether a person has a specific Illness or disease, whether or not there is a family history of such Illness or disease, where the person has experienced no symptoms, except for routine colonoscopy screenings and mammograms as described in this Summary Plan Description; (b) for employment; or (c) for licensing (driving or piloting).

8. Any services or treatments not prescribed by a Physician. This exclusion applies to items such as vitamins, cough medicine, aspirin, Nicorette, cosmetics, soap, toothpaste, etc.

9. Any care, treatment, or surgery that is elective and not Medically Necessary or otherwise specifically stated in the Plan as a Covered Expense, such as non-Emergency plastic or cosmetic surgery on the body (including but not limited to such areas as the eyelids, nose, face, breasts, or abdominal tissue). However, this exclusion does not apply to the following:

    a. Cosmetic surgery for the correction of defects incurred through traumatic Injuries due to an accident which occurred while the Eligible Individual was Covered Under

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

b. Correction of congenital defects;

c. 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;

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

e. 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 services, laboratory tests, inpatient services and artificial and intrauterine insemination procedures but in no event will the benefit extend to prescription drugs.

15. [RESERVED].

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 diabetes management education, celiac disease nutritional education, and nutritional counseling for mental health and substance abuse disorders, up to the applicable lifetime maximum benefit 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 hospitalization, the period of a normal maternity hospitalization is used, except as limited by federal law regarding hospital stays in connection with childbirth.

    Once nursery charges for a newborn Dependent Child are terminated, benefits will be payable only if all other eligibility rules of the Plan have been met for that Dependent Child and the Fund Office has been notified of the birth.

29. Expenses for services to treat Illnesses and Injuries incurred in, or aggravated during, performance of service in the uniformed services.

30. Any expense for dental services and supplies given for treatment of the teeth, the gums (other than tumors) or other associated structures primarily in connection with the treatment, realignment, or replacement of teeth, including treatment given 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 and including dental surgery, dental treatment, dental x-rays, or any care of the teeth and gums except as specifically indicated as a Covered Medical Expense. (This exclusion does not apply if the charges are for the repair of Injury to sound natural teeth or are specified as payable under the Plan's Medical Coverage or Dental and orthodontic benefit).

31. Any charge for travel, whether or not recommended by a Physician, except as specified in the definition of Covered Medical Expenses.

32. Any treatment, care services, supplies, procedures or facilities that are Experimental or Investigative, except for drugs approved for distribution through the U.S. Food and Drug Administration's expanded access or "compassionate use." The use of an investigational drug outside a clinical trial to treat an Eligible Individual with a serious or immediately life-threatening disease or condition who has no comparable or satisfactory alternative treatment option may be permitted if standard treatment protocols have failed.

33. Any care or treatment of an Eligible Individual once that Eligible Individual has already received Plan benefits totaling the maximum benefit for that type of care and treatment except as governed by any applicable restoration, reinstatement, or extension of benefits provision.

34. Any charge for treatment, care, services or supplies that are not Medically Necessary.

35. Any charge for treatment of alcoholism, drug addiction, or Mental or Nervous Disorders (except as provided under the "Mental Health and Chemical Dependency Benefits" section of this Summary Plan Description).

36. Any loss, expense, or charge for which a third party or insurer may be liable for which the individual on whose behalf the claim was filed did not submit the required subrogation and reimbursement acknowledgement form.

37. Any charge for individual or private nursing care (except as provided under the "Home Nursing Care" section of this Summary Plan Description).

38. Any charge or portion of a charge that is determined to be greater than the amount considered to be Reasonable and Customary.

39. Expenses related to an Injury or Sickness that results from an incident occurring on any property where the lessee, lessor or owner of said property is responsible for Injury or Sickness or which is otherwise covered under homeowner's insurance or commercial liability or other insurance policy. The Plan will consider the charges only if no insurance or other form of compensation is available to the affected Eligible Individual, provided that the Eligible Individual (the individual responsible for payment of expenses) signs a subrogation and reimbursement acknowledgment with the Plan.

40. Any charge to an Injury or Sickness related to an automobile accident where the Eligible Individual fails to maintain the statutory minimum level of no-fault automobile medical insurance protection or other state required automobile related insurance, provided that the Eligible Individual is required by Minnesota or other state statutes to maintain this coverage, subject to the Plan provisions entitled “Right of Subrogation/Reimbursement.”

    EXCEPTION: This exclusion does not apply to any charges for any Injury or Sickness related to any automobile accident where the Eligible Individual:

    a. Maintains the statutory minimum level of no-fault automobile medical insurance protection obtained through the Minnesota assigned claims plan;

    b. Charges incurred as the result of any automobile accident where the Eligible Individual is a passenger in a non-owned automobile; and

    c. Charges incurred as the result of any automobile accident where the Eligible Individual is a pedestrian.

41. Any loss, expense or charge arising from the maintenance or use of an automobile where the Eligible Individual fails to apply for benefits available from no-fault automobile insurance or the no-fault insurer has determined that charges are not Medically Necessary, Reasonable or Customary.

42. Any loss, expense or charge for which a third party may be liable and for which either:

    a. A recovery subject to the Plan’s subrogation and reimbursement rights has been received (before or after the claim has been submitted or paid); or

    b. The Plan deems it likely that recovery will be received.

43. This exclusion applies to any recovery received by an Eligible Individual regardless of how it is characterized, including, but not limited to, any apportionment to a Spouse for loss of consortium. The term "third party" as used in this section includes any individual, insurer, entity, or federal, state or local government agency, who is or may be in any way legally obligated to reimburse, compensate or pay for an individual's losses, damages, injuries or claims relating in any way to the Injury, Sickness, occurrence, condition or circumstance for which the Plan has paid medical, dental or disability benefits. This includes but is not limited to insurers providing liability, medical expense, wage loss, uninsured motorist or underinsured motorist coverage.

44. Any loss, expense or charge incurred as a result of any Injury, occurrence, condition or circumstance for which the injured Eligible Individual:

    a. 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 right of subrogation or reimbursement;

    b. Has recovered from a third party;

    c. Has not submitted a claim for such loss, expense or charge prior to resolution of the third party claim; or

d. At the discretion of the Trustees, losses, expenses and charges excluded by this paragraph may be paid subject to the Plan's right of subrogation and reimbursement.

This exclusion applies to any recovery received by an Eligible Individual regardless of how it is characterized, including, but not limited to, any apportionment to a Spouse for loss of consortium. The term “third party” as used in this section has the same meaning as used in Item No. 43 above.

45. Any expenses due to Injury, Sickness, Condition, disease, or Mental or Nervous Disorder for which benefits are or may be payable, in whole or in part, under any Worker's Compensation Act or any Occupational Diseases Act, or any similar law. However, the Fund will consider advancing medical expenses payable under Worker's Compensation law if the Eligible Individual signs a subrogation agreement and agrees to pursue a claim;

46. Any expense relating to an Injury or Sickness of any Eligible Individual if information requested by the Fund Office is not timely completed and supplied, including periodic claim information letters relating to the accident.

47. Rental or purchase of any durable medical equipment or other equipment that is not used solely for therapeutic treatment of an Eligible Individual’s Injury or Sickness.

48. Any charge for the following 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 and scales (except elastic bandages or stockings, wigs, and devices or surgical implantations for simulating natural body contours).

49. Any in- items such as telephones, televisions, cosmetics, newspapers, magazines, laundry, guest trays, beds or cots for guests or other family members or any other personal comfort items or items that are not Medically Necessary.

50. Any expense related to Hospice care (except as provided under the "Hospice Care Program" section of this Summary Plan Description).

51. Any charge for confinement in a nursing facility (except as provided under the “Skilled Nursing Facility Care" section of this Summary Plan Description).

52. Expenses related to radial keratotomy or LASIK procedure.

53. Any charge connected with an Injury or Sickness for which the Eligible Individual is not under the regular care of a Physician.

54. Charges connected with an inpatient or outpatient hospitalization related to dental treatment if a Physician of Medicine has not provided written certification that the hospitalization is Medically Necessary for such treatment.

55. Expenses incurred on behalf of an individual for any Sickness or Injury before the date medical benefits become effective.

56. Expenses incurred to treat any Sickness or Injury incurred or aggravated while incarcerated.

57. Charges incurred in connection with acupuncture unless performed by a Physician of Medicine (M.D.) or by a licensed acupuncturist acting within the scope of that licensure and under the supervision of a Physician of Medicine and within acupuncture Maximum Benefits.

58. Any charge for nutritional supplements and/or injections prescribed or administered by a chiropractor.

59. Charges incurred while the Eligible Individual is a member or a dependent of a member of a health maintenance organization (HMO).

60. Any charge related to membership in a health or fitness club or facility, unless otherwise covered by the Plan.

61. Charges related to genetic engineering, except as provided in the Schedule of Benefits.

62. Self-care/home management training (e.g., activities of daily living and compensatory training, meal preparation, safety procedures, and instructions in the use of adaptive equipment), unless specifically described as a covered service under the Plan.

63. Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, and work task analysis), unless specifically described as a covered service under the Plan.

64. Any charge which would not have been made if this Plan did not exist.

65. Charges incurred for any treatments, care, services, or supplies which are in excess of any limitation specified in this Plan, or which are specified as not payable.

66. Any charges or losses incurred by an Eligible Individual at a time that the Eligible Individual owes payment to the Plan because of benefit payments made in reliance upon incorrect, misleading or fraudulent statements or representations by the individual, or where such individual has failed to honor the Plan's rules of subrogation and reimbursement or otherwise has failed to cooperate with the Plan, as described in this Plan Document.

67. Any charges for medical records.

68. Services needed because you engaged in an illegal occupation, or committed or attempted to commit a felony, unless the services are related to an act of domestic violence against you or the illegal occupation or felonious act is related to a physical or mental health condition.

69. Any charges for batteries for any medical device.

70. Private Duty Nursing Care.

71. Shoe wedges (lifts).

72. Wheelchair training.

73. Orthotic management and check out.

74. Treatment of complications arising from an elective medical procedure or treatment or any other medical procedure or treatment that is or would not be covered by the Plan (including complications arising from a medical procedure or treatment that was not covered by the Plan due to failure to obtain required preauthorization, but not including medical procedures or treatments that were not covered by the Plan because the Eligible Individual was then ineligible for coverage under the Plan for reasons unrelated to the type of medical procedure or treatment or preauthorization requirements, such as ineligibility based on hours of service or due to previous coverage under a Spouse's plan). If the complications arise in part due to a non-covered procedure or treatment and in part due to a covered procedure or treatment, treatment for such complications may be covered to the extent Medically Necessary.

75. "Never Events," such as surgery on the wrong patient, wrong body part, or wrong side of the body.

SITUATIONS THAT AFFECT BENEFIT PAYMENTS

This Section applies to the Plan's Medical Coverage, Dental Coverage, and Vision Care Plan. It does not apply to the Plan's Loss of Time Benefits, Maternity Leave Benefits, Accidental Dismemberment Benefits or Life Insurance Benefits.

Coordination of Benefits with Other Plans

If an Eligible Individual has duplicate coverage under This Plan and any Other Plan, benefits will be coordinated between the two plans. This provision is commonly called coordination of benefits or COB.

The Order of Benefit Payments Subsection governs the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense. Generally, This Plan is the Secondary Plan unless the Other Plan has coordination of benefits provisions and those provisions and This Plan's provisions both say This Plan is the Primary Plan.

IMPORTANT: If an Eligible Individual incurs medical expenses that are covered by two different Plans, the Eligible Individual must file the claim with BOTH Plans and provide all requested information to BOTH Plans. The claim departments of the two Plans then will decide which Plan is the Primary Plan and which Plan is the Secondary Plan. If the Other Plan is the Primary Plan and This Plan is the Secondary Plan, you must file your claim with This Plan within one hundred twenty (120) days of the Primary Plan's adjudication of the claim. Such a claim must be made in compliance with the requirements described in the section of This Plan entitled "Claiming Your Benefits."

Definitions Applicable to this Section

The terms **"Other Plan"** or **"Another Plan"**, as used in this Section, mean any plan providing benefits or services for, or by reason of, medical, dental, or vision care, treatment, or healing which benefits or services are provided by:

- Group and nongroup insurance contract and subscriber contracts;
- Uninsured arrangements of group or group-type coverage;
- Group and nongroup coverage through Closed Panel Plans;
- Group-type contracts ("Group-type contract" means a contract that is not available to the general public and is obtained and maintained only because of membership in, or a connection with, a particular organization or group, including blanket coverage);
- The medical care components of long-term care contracts, such as skilled nursing care;
- The medical benefits coverage in traditional "no-fault" and "fault" type insurance contracts, such as automobile no-fault policies, premises liability or homeowners contracts;

- Any coverage for students which is sponsored by or provided through a school or other education institution;

- Any coverage under federal or state or other governmental programs, except Medicare, and any coverage required or provided by statute;

- Coverage under a labor-management trusteed plan, union welfare plan, Employer organization plan or employee benefit organization plan; and

- Medicare. For the purposes of this Section, the definition of Medicare includes both Part A and Part B of Medicare, whether or not the Eligible Individual is enrolled for both parts; and

- Qualifying Employer Health Care Coverage.

The term **"Other Plan"** or **"Another Plan"** will not mean:

- Hospital indemnity coverage or other fixed indemnity coverage;

- Accident only coverage, except no-fault coverage;

- Specified disease or specified accident coverage;

- Limited benefit health coverage, as defined by state law;

- School accident type coverage that cover students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis;

- Benefits for non-medical components of long-term care policies, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, Respite Care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or receipt of services;

- Medicare supplement policies; or

- A state plan under Medicaid.

The term **"Plan"** is construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not. Notwithstanding the foregoing, the term "Plan" includes any plan which is paid for entirely by an Employee, Retiree or Dependent only if such plan contains a provision coordinating its benefits with This Plan.

The term **"This Plan"** means that portion of the I.B.E.W. 292 Health Care Plan which provides the medical, dental, and vision benefits subject to these COB provisions.

The term **"Allowable Expense"** means any Medically Necessary, Reasonable and Customary item of expense at least a portion of which is covered under at least one of the Plans covering the Eligible Individual with respect to whom claim is made. 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 both an Allowable Expense and a benefit paid. The Trustees are not required to determine the existence of, benefits payable under any Plan except This Plan. The payment of benefits under This Plan are 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 Eligible Individual or any insurance company or other organization or person. An expense that is not covered by any Plan covering the Eligible Individual is not an Allowable Expense. In addition, any expense that a provider, by law or in accordance with a contractual agreement, is prohibited from charging an Eligible Individual is not an Allowable Expense.

The term **"Claim Determination Period"** means a period of one year commencing on January 1.

The term **"Closed Panel Plan"**, as used in these COB provisions, means a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

The term **"Custodial Parent"** as used in these COB provisions, means the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the Child resides more than one half of the Calendar Year excluding any temporary visitation.

Order of Benefit Payments

Provided that This Plan does not otherwise exclude or limit coverage, the order of benefit payments is as follows:

- **No Coordination of Benefits Provisions**. If the Eligible Individual is covered under Another Plan that does not coordinate benefits, the Other Plan is primary, and This Plan is secondary;

- **Individual Policy or Plan**. If the Eligible Individual is covered under Another Plan that is a nongroup or individual policy or plan, the Other Plan is primary, and This Plan is secondary;

- **Non-Dependent or Dependent**. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree, is the primary Plan and the Plan that covers the person as a dependent is the secondary Plan;

- **Medicare Beneficiary**. If the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the

person as an employee, member, policyholder, subscriber or retiree is the secondary plan and the other Plan is the primary Plan;

- **Dependent Spouse**. If an Eligible Employee or Eligible Retiree and his or her Spouse are both Covered Under This Plan as an Employee, any claim incurred by either Spouse will be paid first as the claim of an Employee and will then be coordinated as the claim of a Dependent of the other Spouse;

- **Active Employee or Retired or Laid-Off Employee**. The Plan covering the Eligible Individual as an employee who is not retired or laid-off (or as that employee's dependent) is the primary Plan. The Plan covering that same person as a retired or laid-off employee (or the dependent of the retired or laid-off employee) is the secondary Plan;

- **Dependent Child Covered Under More Than One Plan**. Unless there is a Qualified **Medical** Child Support Order (QMCSO) (as defined below) stating otherwise, when a Dependent Child is covered under more than one Plan, the order of payment is determined as follows:

  - When The Parents Are Not Separated Or Divorced Or Are Living Together.

    1. 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);

    2. If both parents have the same birthday, the Plan that has covered the parent the longest is the primary Plan; and

    3. If a parent's Plan does not have this "birthday rule," the provisions of that Plan will determine the order of benefit payments for Eligible Dependent Children claims.

  - When The Parents Are Separated, Divorced, Or Were Never Married To Each Other And Are Not Living Together.

    1. If there is no QMCSO establishing financial responsibility for the Dependent Child's health care expenses or health care coverage, the order of benefits for the Child are as follows:

       a. The Plan covering the Custodial Parent;

       b. The Plan covering the Spouse of the Custodial Parent;

       c. The Plan covering the non-Custodial Parent; and then

       d. The Plan covering the Spouse of the non-Custodial Parent.

    2. If the QMCSO establishes financial responsibility for the Child's health care expenses or health care coverage, the Plan covering the Child as a dependent of the parent with that responsibility is the

primary Plan. The Plan covering the Child as a dependent of the parent without that responsibility is the secondary Plan;

3. If the QMCSO states that both parents are responsible for the dependent Child's health care expenses or health care coverage, the Plan covering a parent of the Child as an employee will pay first and This Plan will pay after any such Plan. If each parent of the Child is covered by a Plan or This Plan as an employee, the "birthday rule" described above will determine the order of benefit payments; and

4. If the QMCSO states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage for the dependent Child, the Plan covering a parent of the Child as an employee will pay first and This Plan will pay after any such Plan. If each parent is covered by a Plan or This Plan as an employee, the "birthday rule" described above will determine the order of benefit payments.

- If both you and your Spouse are covered as Employees under This Plan. Claims for your Dependent Children will be coordinated.

► **Dependent That Is Not A Child**. In the case of a Dependent Covered Under This Plan that does not meet This Plan's definition of Child (e.g., a grandchild), a Plan other than This Plan that covers the Dependent will pay first and This Plan will pay after any such Plan or Plans.

► **COBRA Or State Continuation Coverage**. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the Non-Dependent or Dependent rule above can determine the order of benefits payments.

► **Longer Or Shorter Length Of Coverage**. If none of these rules applies, then the Plan that has covered the person for the longest period of time will pay first as the Primary Plan. The Plan which has covered the person for the next longest period of time will pay second and so on.

Effect on Benefits

The provisions of this Section will apply when This Plan is secondary (under the following rules) to one or more Other Plans. In that event, the benefits of This Plan may be reduced under these COB rules.

The benefits of This Plan will be reduced when the sum of:

♦ The benefits that would be payable for the Allowable Expense under This Plan in the absence of these COB provisions and also in the absence of any precertification

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 needs 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 United Healthcare 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.

Whenever any Eligible Individual is physically, mentally, or otherwise incapable of giving a valid release for payment of benefits due, the Trustees have the right to pay Plan benefits to:

- Any person or institution that provided the services for which benefits are payable; or
- Any person or institution appearing to the Trustees to have assumed responsibility for the care, custody or support of the Eligible Individual.

This right does not continue after proper notice is given to the Trustees by a duly appointed guardian for such Eligible Individual.

Whenever any Eligible Individual dies before medical benefits due under the Plan are paid, the Trustees will pay Plan benefits to:

- Any person or institution for that provided the services for which benefits are payable, or if none; then
- The surviving Spouse, or if none; then
- The executor or administrator of deceased Eligible Individual's estate.

Amounts so paid are benefits paid under This Plan and to the extent of such payments, the Trustees will be fully discharged from liability under This Plan.

Right of Recovery

Whenever payments have been made by This Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at the time to satisfy the intent of this Section, or whenever payments made are determined to have been made to the wrong person, the Trustees, without the consent of or notice to any person, have the right to recover such payments to the extent of such excess, from one or more of the following, as the Trustees determine appropriate: (1) any persons to or for or with respect to whom such payments were made; (2) any insurance companies; or (3) any other organizations. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Coordination of Benefits with Automobile, Motorcycle, Watercraft, Other Recreational Vehicle or Motorized Vehicle Insurance

This Plan will coordinate benefits with automobile, motor cycle, watercraft, other recreational vehicle or any other form of Motorized Vehicle (collectively "Motorized Vehicle") insurance coverage as described below:

- 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 or other insurance that provides medical or wage loss coverage within the jurisdiction in which that individual resides;
- For any expenses arising from the maintenance or use of an automobile, motor cycle, watercraft, other recreational vehicle or Motorized Vehicle, no-fault insurance will calculate

and pay its benefits first and This Plan will calculate and pay benefits second. The amount of benefits payable by This Plan will be coordinated so that the total amount paid will not exceed the lesser of the benefit amount that would be payable under This Plan or 100% of the expenses incurred; and

- Benefits that otherwise might be payable under no-fault insurance will not be payable by This Plan merely because no claim for no-fault benefits was filed. If an Eligible Individual fails to maintain the legally required amount of no-fault insurance within the jurisdiction where the Eligible Individual resides, Plan benefits will not be payable for amounts which the legally required no-fault insurance otherwise would have paid.

This Plan may require an Eligible Individual injured in an automobile, motor cycle, watercraft, other recreational vehicle or Motorized Vehicle accident to arbitrate any denial, notice of discontinuance or non-payment of no-fault insurance or benefits before a claim will be considered under This Plan.

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, Motorized Vehicle policy, homeowner's policy, or premises insurance policy.

This Plan may require that an Eligible Individual show that he or she has made a reasonable effort to find out if there is another applicable insurance policy before benefits will be considered under This Plan. Benefits that might otherwise be payable under another insurance policy will not be paid by This Plan merely because the Eligible Individual has not made a claim under the other insurance policy.

Coordination with State Medicaid Payments

Payment of benefits under the Plan with respect to any Eligible Individual will be made in accordance with any assignment of rights made by or on behalf of such Eligible 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 such Act ("State Plan"). In enrolling an Eligible Individual or in determining or making any payment of benefits for or on behalf of an Eligible Individual, the Plan will not take in to account the fact that such person is eligible for or is provided medical assistance under an applicable State Plan. In any case in which the 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 any applicable State Plan, such payment by the Plan will be made in accordance with any applicable state law which provides that the state has acquired a right to payment for such items or services with respect to the Eligible Individual.

Coordination of Benefits with Medicare

- **For Retirees Eligible for Medicare**. A Retiree who is eligible for Medicare and the Retiree has, or could have, enrolled in Medicare Parts A and B, 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. Retirees who are eligible to enroll for Medicare Part B, but who do not enroll when first eligible, will be subject

to lesser benefits. Benefits will be paid as though the Retiree had enrolled in Medicare Part B. Benefits will be coordinated using the Schedule of Benefits for Eligible Employees.

- **Private Physician Contracts in Lieu of Medicare**. This Plan will not provide benefits for services provided to those who are enrolled, or eligible for enrollment, in Medicare Parts A and B by Physicians who have decided to use private contracts for providing medical services in lieu of participating in Medicare. If an Eligible Individual is currently enrolled, or eligible for enrollment, in Medicare and the Physician he or she intends to visit does not participate in Medicare, please contact the Plan Administrator for more information regarding this exclusion from coverage.

- **For Persons under 65 (Employees and their Dependents only).** If an Eligible Employee or his or her Eligible Dependent is Totally Disabled and is eligible for Medicare under the Medicare disability rules, Medicare will usually pay first on the Covered Person's claims and this Plan will pay second. However, federal law sometimes may require this Plan to pay first as follows:

  - If an Eligible Employee or Eligible Dependent is entitled to Medicare for reasons other than being sixty-five (65) or older This Plan may pay before Medicare pays. Contact the Plan Administrator to see if this rule applies;

  - This Plan may pay before Medicare pays for an Eligible Employee or Eligible Dependent is eligible for Medicare by reason of End Stage Renal Disease (ESRD) if the Eligible Employee or Eligible Dependent is eligible under This Plan through either self-payments or Employer Contributions. In the event an Eligible Employee or Eligible Dependent is required to enroll in Part A and Part B of Medicare solely because of ESRD, This Plan will provide benefits subject to the following terms:

    1. Benefits payable under This Plan will be limited to the Covered Medical Expenses incurred during the initial thirty (30) consecutive months of treatment, beginning with either: (i) the first month in which renal dialysis treatment is initiated; or (ii) in the case of a transplant, the first month in which the individual could become entitled to Medicare, providing a timely application was filed; and

    2. Benefits payable under This Plan beginning with the 31st month of treatment will be reduced by the amount of benefits paid or payable under Part A or Part B of Medicare.

  This provision (for persons under age sixty-five (65)) does not apply to Retirees or their Dependents.

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 which is or purports to be an "excess policy" or "excess plan" paying benefits only in excess of benefits provided by another plan or policy. An "excess policy" or "excess plan" pays benefits only in excess of benefits provided by any other plan or policy.

If an entity or insurer of another group's "excess plan" or "excess policy" agrees to pay benefits as if it were not an excess plan or policy, this Plan's benefits will be payable without regard to the provisions of the previous paragraph, subject to the coordination of benefits provisions stated earlier in this Plan.

Qualified Medical Child Support Order

A medical child support order is a court or administrative order requiring child support for health care coverage of a Member's or Employee's Child, or requiring Plan coverage for the Child. It can take the form of a National Medical Support Notice, which is a standardized medical child support order used by state child support enforcement agencies to enforce medical child support obligations. The order is generally issued to protect the benefit coverage of children in cases of divorce.

The Fund Office will notify an Eligible Employee or Eligible Retiree if the Plan receives a medical child support order that affects the Eligible Employee or Eligible Retiree. An Eligible Employee or Eligible Retiree who receives a medical child support order, must notify the Fund Office as soon as possible. The Fund Office will then follow the Plan's written procedures for determining whether the order meets all the applicable legal requirements and so qualifies as a Qualified Medical Child Support Order ("QMCSO"). At any time, an Eligible Individual may, upon request, obtain a copy of the written QMCSO procedures free of charge from the Plan Administrator.

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) protects the reemployment rights and benefits of civilian employees who enter the military "for a brief, non-recurrent period and have no expectation of significant continuing military service."

This protection extends to Employees who perform uniformed military service on a voluntary or involuntary basis for a cumulative period of service of five years or less. "Uniformed military service" includes: active duty, active duty for training, initial active duty, full-time National Guard duty, and a period during which a person is absent from work for the purpose of examination to determine his or her fitness for military service. Uniformed services include the Army, Navy, Air Force, Marine Corps, or Coast Guard, Reserve Units of those groups, the Army and Air National Guards, the Commissioned Corps of the Public Health Service, and any other category of persons designated by the President in a time of war or emergency.

How Your Benefits Are Protected

When an Eligible Employee or Eligible Retiree is away from Covered Employment due to uniformed military service covered by USERRA and returns to work for a Contributing Employer following an honorable discharge, the health benefits of the Eligible Employee or Eligible Retiree will be protected as follows:

- No permanent break in service may occur as a result of military service;
- Forfeiture of already earned benefits is not allowed; and
- There is no need to re-qualify for participation in the Plan due to absence for military service.

However, if an Eligible Dependent enters military service, the Eligible Dependent's coverage under the Plan stops on the date the military service begins.

Your Options

1. If you provide a copy of your active duty orders (but do not provide a written request to continue Plan coverage during that military service) to the Plan Administrator before the date you enter military service covered by USERRA:

   Your Premium Credit Account will be frozen and your Plan coverage will stop on the date you enter military service. Even so, coverage for your Eligible Dependents will continue at no cost to you, so long as your active duty lasts at least sixty (60) days, and you neither voluntarily enlisted nor reenlisted. That Dependent-only coverage will terminate on the earlier of: (1) the date you are discharged; or (2) the end of twenty-four (24) months of Dependent-only coverage. Coverage will be reinstated according to the section of this booklet entitled "Coverage Following Military Service."

2. If you provide a copy of your active duty orders (as well as a written request to continue Plan coverage during that military service) to the Plan Administrator before the date you enter military service covered by USERRA:

   Plan coverage will continue for you and your Eligible Dependents under the "Military Continuation Coverage" option. Under this option, you choose between paying for continuing coverage by way of: (1) Self-Contributions alone (in which case your Premium Credit Account will be frozen); or (2) Self-Contributions after application of your Premium Credits. You must deliver, to the Fund Office, any Self-Contribution due for a particular month's coverage by the first day of that month. In any event, military continuation coverage will terminate on the earliest of: (1) the first day of a month for which a Self-Contribution was due but not received by the Plan Administrator within thirty (30) days of the due date; (2) the end of twenty-four (24) months of military continuation coverage paid for by Self-Contributions; or (3) the day after the last date on which you must apply for or return to work with a Contributing Employer (See "Time Limits to Return to Work" below).

3. If you do not provide a copy of your active duty orders to the Plan Administrator before the date you enter military service covered by USERRA:

   Plan Coverage will continue according the Plan's provisions governing "CONTINUING ELIGIBILITY" as if you had never entered military service. One consequence of this rule is that your Premium Credit Account will continue to be charged for coverage, regardless of whether you or any of your Eligible Dependents receives Plan benefits for charges incurred during your period of military service.

Coverage Following Military Service

If and when you 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 to Return to Work, below, and only if you were honorably discharged, the eligibility status you had upon entering military service will be restored, subject to the provisions below:

- Your Premium Credit Account will reflect any Contributions added while you were performing military service as well as the impact of freezing or continuing coverage, as the case may be, during military service. If you elected to freeze your coverage at the time your leave began, you may elect to use any available Premium Credits to cover the cost of coverage. If you exhausted your Premium Credits to pay for coverage while on military leave, you may make self-payments to resume your eligibility for coverage under the Plan until such time as you have received sufficient Contributing Employer Contributions for coverage; and

- Your Premium Credit Account will reflect any Contributions added while you were performing military service as well as the impact of freezing or continuing coverage, as the case may be, during military service. Contact the Plan Administrator to determine your Premium Credit Account balance and learn what activity took place in your account during your military service.

Regardless of the election you made, if your Premium Credit Account balance equals less than one month's worth of premiums, you will need to pay the difference before you or your Eligible Dependents will be covered again. Conversely, if your Premium Credit Account balance equals at least one month's worth of premiums, eligibility will be automatically reinstated for you and your Eligible Dependents.

Time limits to return to work

If you were in military service:	You must return to work for a Contributing Employer or sign the book:
1 to 30 days	By the beginning of the first regularly scheduled work day beginning more than eight hours after your date of discharge.
31 to 180 days	Within 14 days after your date of discharge.
More than 180 days	Within 90 days after your date of discharge.

These time limits may be extended if you suffered a service-connected Injury or Illness, and you should contact the Plan Administrator if you did.

Also, within fourteen (14) days of returning to work or signing the book as indicated above, you must deliver to the Plan Administrator: (1) copies of your discharge papers showing the date of induction, date of discharge or termination of duty, and whether the discharge was honorable; (2) the identity of the Contributing Employer you are working for (or the date you signed the book); and (3) whether that Contributing Employer is the same Employer you worked for immediately before entering military service.

Family and Medical Leave Act of 1993 (FMLA)

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

Contributing Employer over the previous twelve (12) months. Your Contributing Employer is responsible for determining your eligibility for FMLA leave.

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

Continued Coverage Due to a Qualifying Condition

You may be entitled to continued Plan eligibility for up to twelve (12) weeks if you qualify for FMLA leave. You may also be eligible for continued Plan eligibility for up to twelve (12) weeks if you are away from work due to a Qualifying Condition and have worked for one or more Contributing Employers for a combined total of at least one year, and you have worked at least 1,250 hours for one or more Contributing Employers over the previous twelve (12) months.

Advanced Notice and Medical Certification

The Plan is responsible for determining if you meet the requirements for continued Plan eligibility due to the occurrence of a Qualifying Condition. To determine eligibility, the Plan may require your permission to obtain information regarding your employment from your Contributing Employer(s).

The Plan may require you to provide advanced notice and medical certification before any request for continued Plan eligibility is granted. A request for continued Plan eligibility 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 or other leave for a Qualifying Condition when it is foreseeable;
- If a Qualifying Condition is not foreseeable, notice must be provided as soon as practicable;
- The Plan may require you to provide medical certification to support a request for continued Plan eligibility to a Qualifying Condition; and
- The Plan may require your permission to obtain information regarding your employment from your Contributing Employer(s).

Qualifying Conditions

You may be entitled to continued Plan eligibility if you satisfy the employment requirement and you experience a Qualifying Condition. A Qualifying Condition is any of the following:

- To care for your Child after the birth or the placement of a Child with you for adoption or foster care;
- To care for your Spouse, Child, foster Child, adopted Child, stepchild or parent who has a serious medical 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 years before the date the veteran undergoes the medical treatment, recuperation or therapy;

- To care for a service member whose serious Injury or Illness 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 injury or illness" 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 Injury or Illness rises to the level of a subsequent Injury or Illness will an Employee be entitled to take leave for the same covered service member;

- For Qualifying Exigency Leave.

    - 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 exigency leave, 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.

In the event you or your Spouse are both Covered Under this Plan as Employees, the continued Plan eligibility due to caring for a newborn Child or an adopted Child cannot exceed a total of twelve (12) weeks. In addition, if continued Plan eligibility is due to caring for a parent with a serious health condition, the continued coverage may not exceed a combined total of twelve (12) weeks.

Intermittent Leave

The FMLA permits employees to take leave on an intermittent basis or to work a reduced schedule under certain circumstances. Intermittent leave may be taken when Medically Necessary to care for a seriously ill family member, or because of the employee's serious health condition. Intermittent leave may be taken to care for a newborn or newly placed adopted or foster care Child only with your Contributing Employer's approval. Your Contributing Employer is responsible for determining your eligibility for intermittent leave under the FMLA.

If seeking continued Plan coverage during intermittent leave, the Plan may require you to provide additional medical certification. The Plan may not request recertification more often than every thirty (30) days, and may only request recertification in connection with an absence. However, the Plan may always request recertification if circumstances have changed or if the Plan receives information that casts doubt on the employee's reason for the absence.

Continued Coverage While Disabled

If you are unable to perform work because you are Totally Disabled and are receiving disability benefits under the Plan, you may still be eligible for continued eligibility under the Plan due to a Qualifying Condition or FMLA leave. Continued eligibility due to a Qualifying Condition or FMLA leave will run concurrently with any Disability leave.

What to Do If You Would Like to Take an FMLA Leave of Absence

To take an FMLA leave of absence, you and your Employer must meet other conditions. If you would like to apply for continued coverage under the Plan due to a Qualifying Condition, or if you have any questions about continued coverage under the Plan due to a Qualifying Condition, please contact the Fund Office.

CLAIMING YOUR BENEFITS

Rules Governing Payment of Medical Benefits

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

- The Plan may pay benefits for services received at an in-network (United Healthcare) facility directly to the providers (Hospitals, clinics, and Physicians). Generally, the Plan may also pay benefits for services received at an out-of-network facility directly to the providers. The only exception to this is if you have not directed the Plan to make payment to your providers (see the second following bullet).

- Claims for covered services incurred by you or your Eligible Dependent through December 31, 2020 for an ongoing course of treatment that began prior to April 1, 2020, with a provider that was a Blue Cross Blue Shield in-network provider on April 1, 2020 but is a United Healthcare out-of-network provider will be covered at in-network cost share levels based on usual and customary amounts established by the Plan.

- An Eligible Individual, in most cases, can direct the Plan to make payment for benefits the Plan has determined to be payable directly to Physicians, ambulance services, laboratories, etc. This means that the Eligible Individual signs a form that tells the Plan Administrator to pay the Physician, laboratory, etc. directly. If such a request is made, the Plan Administrator will make the payment to the provider as directed and will not make payments to the Eligible Individual. If there is a circumstance in which the Plan does not accept such a request, the Plan will make payment to the Eligible Individual, and the Eligible Individual in turn must pay the provider. In such a case, the Plan will only make payment once and the Eligible Individual will be obligated to make payment to the provider.

  Note: If the Plan pays benefits to a provider, and the Eligible Individual also pays the provider, any reimbursement due to you must be collected from the provider, not the Plan. Although the Plan may make payments directly to providers, such payments do not make a provider an assignee for any purposes or otherwise confer on the provider any rights under the Plan or ERISA. Any attempt to assign rights or benefits to a third party is null and void absent written consent by the Plan.

- Benefit charges to providers will be paid as follows:

  - In-Network Providers: For benefit charges incurred with in-network providers, the Plan will pay a discounted amount. These providers have agreed to accept payment from the Plan as payment in full, except for applicable copayments, deductibles, coinsurance, maximum benefit limitations or other similar limitations under the Plan.

  - Out-of-Network Providers Treated as In-Network Providers. For benefit charges incurred with certain out-of-network providers in the circumstances described above in the “No Surprises Act” topic in the “Medical Coverage” section of this Summary Plan Description, the providers must, by law, accept payment from the Plan as payment in full, except for applicable copayments, deductibles, coinsurance, maximum benefit limitations, or other similar limitations under the Plan; and

- Out-of-Network Providers Generally: Benefit charges incurred with out-of-network providers in situations other than those described above (describing situations when certain out-of-network providers are treated as in-network providers under the No Surprises Act), the Plan will pay the Reasonable and Customary Charge or, if applicable, an amount separately negotiated amount to the non-participating providers. Eligible Individuals 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 out-of-network provider.

♦ Payments are made for treatment of Injuries and Sicknesses only if they are non-occupational that is, not related to work. (Occupational Illnesses or Injuries may also be covered by this Plan if the Eligible Individual has signed a subrogation and reimbursement agreement and has been denied for worker's compensation benefits. Contact the Fund Office if you have questions about coverage for occupational Injuries or Illnesses).

♦ 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.

♦ Charges are considered for payment only if they are incurred while the Eligible Individual is Covered Under this Plan. 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.

♦ Reasonable and Customary expenses actually incurred by a female Eligible Individual for a maternity or pregnancy-related condition are treated the same as expenses incurred for any other Illness or Injury. For this purpose, the term “pregnancy” includes spontaneous abortion, miscarriage, normal childbirth, caesarian section, extra-uterine pregnancy, or any related complications.

♦ A year is defined as a Calendar Year, which begins on January 1 and ends on December 31 of that same year.

♦ Your life insurance benefit will be paid to your designated Beneficiary.

♦ If the Trustees decide that an Eligible 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 an Eligible Individual 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 Eligible Individual the Trustees believe is entitled to the benefits.

♦ Benefits are payable only when the required forms and information have been received by the Fund Office.

♦ Any payments made by the Plan according to the above rules will fully discharge the Plan's liability to the extent of its payments.

There are conditions, limitations and exclusions which apply to certain types of charges. Refer to the "Exclusions and Limitations" section of this handbook for more information.

Filing Medical Claims

The Fund Office will not pay a claim on behalf of a Dependent Spouse of an Eligible Employee unless the Eligible Employee has first provided a certified copy of the marriage certificate to the Fund Office. Similarly, the Fund Office will not pay a claim on behalf of an Eligible Employee's Dependent Child unless the Eligible Employee has first provided a certified copy of the Child's birth certificate to the Fund Office.

Filing In-Network Medical Claims

In-network (i.e., UnitedHealthcare Choice Plus network) providers will file all claims on behalf of the Eligible Individuals. An Eligible Individual who chooses to use in-network providers need only present his or her medical ID card when obtaining medical treatment.

Effective May 1, 2022, the same rules also apply to certain out-of-network medical claims that are treated as in-network medical claims under the No Surprises Act and the Consolidated Appropriations Act, 2021. See the "No Surprises Act" topic under the "Medical Coverage" section of this Summary Plan Description above for more information.

Filing Out-of-Network Medical Claims (Other Than Out-of-Network Claims Treated as In-Network Claims)

An Eligible Individual who has a medical claim through an out-of-network provider (except in the circumstances described above, relating to the No Surprises Act) must follow these steps:

Step 1: File a medical claim as soon as the medical expenses are incurred.

Step 2: Include all the itemized bills (showing CPT code and ICD-9 code) relating to the claim such as drug bills and Physician bills. Each bill must show the name of the patient, the date and the charge for each service rendered and the Sickness or Injury for which each item of expense was incurred. Out-of-network prescription claims for Emergency care must be submitted to the prescription card service. Please see your prescription drug card for the address.

Step 3: Submit the itemized bills and claim forms to the Fund Office.

For dental, vision care, loss of time, maternity leave benefits, accidental death or dismemberment, or life benefits, refer to those sections.

Follow the proper claim filing procedures explained in this handbook when filing a claim. The Fund Office will send a written notice if it cannot process a claim because information is missing. The notice will state why the claim cannot be completed and what additional information is needed. It is your responsibility to send this additional information to the Fund Office within the specified time period.

Approval or denial of a claim will usually be made within ninety (90) days after all necessary information is received. You will be notified if more time (up to an additional ninety (90) days) is needed.

Notice and Proof of Medical Claim and Claim Filing Deadline

Medical claims must be submitted to the Fund Office, by the earlier of either: (i) within one hundred twenty (120) days of the date a service covered by the Plan is rendered, a supply is used or delivered to the Claimant, or, in the case of an inpatient facility stay, a Claimant's admission; or (ii) any claim filing deadline prescribed in the health care provider's applicable Provider Network Agreement, unless the Claimant can show it was not reasonably possible to do so and the Claimant files the claim as soon as possible. Each claim must provide sufficient personal information, a description of the Injury or Sickness, and any itemized bills for treatment or other required forms that help to provide proof of the Injury. Except when the Claimant is legally incapacitated, no benefits will ever be paid for medical claims submitted to the Fund Office more than 15 months after the date the claim was incurred.

In response to COVID-19, the Plan adopted temporary rules in response to Department of Labor and Internal Revenue Service guidance providing extended timeframes related to filing medical claims.

Starting on March 1, 2020, the deadline to file a medical claim was suspended during a "Tolling Period," which ends on the earlier of:

- Sixty (60) days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the "Outbreak Period"); or
- One (1) year from the date the Eligible Individual was first eligible for relief from the deadline related to filing medical clams. The earliest date that an Eligible Individual was first eligible for relief from a deadline related to filing medical claims was either:
    - March 1, 2020 for medical services provided on or before March 1, 2020, including periods during which a claim was required or permitted to be filed that began before March 1, 2020. To be in this window, the last day of the applicable deadline must have been on or after March 1, 2020; or
    - The date medical services were provided after March 1, 2020, but before March 1, 2021.

The calculation of an individual's Tolling Period and relief from deadlines and suspension of certain requirements is fact-specific and is analyzed as to each Eligible Individual. The Tolling Period may not exceed one (1) year. If the medical services were provided prior to March 1, 2020, the number of days by which an Eligible Individual is required to take action after the Tolling Period is shortened by the number of days between the date that medical services were provided and March 1, 2020.

CLAIMS APPEAL (FOR ALL BENEFITS)

Time Limits for Deciding Claims.

- **Claims Requiring Preauthorization (also called Pre-Service Claims)**. If the Plan states that a procedure requires preauthorization before it will be treated as a Covered Expense, the Eligible Individual or Beneficiary (also called a "Claimant") must submit the claim or the suggested course of treatment to the Fund Office well in advance of the service or treatment being performed. When a claim is submitted for which

preauthorization is required, the Plan will notify the Claimant if the claim is authorized within 15 days of the Plan receiving the claim. 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 the Claimant 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 the Claimant's failure to provide the Plan with all the information it needs to process the claim, the Claimant will have forty-five (45) days after the Plan asks for additional information in order to give the additional information to the Plan. If the Claimant failed to follow the Plan's procedures for filing the claim, the Plan will notify the Claimant of this failure within five (5) days of it receiving the claim.

Pre-Service Claims are those claims for which a Claimant's receipt of a benefit from the Plan is conditioned, in whole or in part, on approval from the Plan prior to the Claimant receiving the medical care.

- **Urgent Care Claims**. The Plan will waive its preauthorization requirements if a Claimant has Emergency Services performed that would otherwise be covered under the Plan (this is also known as "urgent care"). The Claimant or the provider, however, must notify the Fund Office as soon as reasonably possible after the services are performed. The Claimant will not be penalized for failing to obtain a preauthorization in an Emergency situation, but the Plan will only pay the Reasonable and Customary Charge for services that are determined to be Medically Necessary.

  An urgent care claim is a claim which: (a) involves a procedure that requires preauthorization under the Plan either in a pre-service situation or for an extension of care in a concurrent care situation; and (b) if applying the preauthorization time frames for determining the claim could seriously jeopardize the life or health of the Claimant, could seriously jeopardize the ability of the Claimant to regain maximum function, or would subject the Claimant to severe pain without the treatment that is the subject of the claim.

- **Concurrent Care Claims**. If the Plan reduces or terminates coverage for treatment before the end of the course of treatment, it will notify the Claimant far enough in advance of the termination or reduction in treatment to allow the Claimant to appeal the Plan's decision to the Plan.

  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 coverage for the treatment before the end of the scheduled treatment.

- **All Other Medical Claims**. If the Plan denies coverage for a medical claim, it will do so within 30 days of the Plan's receipt of the claim from the Claimant or the Claimant's provider. In certain situations, the Plan may extend this by an additional 15 days; if it does, it will notify the Claimant of the extension within the original 30 days and will provide the Claimant the reasons for the extension and when the Plan expects to make a decision on the claim. If the extension is needed because the Claimant failed to submit the necessary information to the Plan, the Plan will notify the Claimant of the information it needs and will give the Claimant 45 days to provide the needed information to the Plan.

- **Disability Benefit Claims**. If the Plan denies a claim on the basis of a disability determination, it will do so within forty-five (45) days of receiving a completed application

for such benefits. The Plan will notify the Claimant of (1) its decision, or (2) a thirty (30) day extension of the decision required by matters beyond the Plan's control (as well as a description of the circumstances requiring the extension and the expected decision date). Within any such extension period, the Plan will notify the Claimant of (1) its decision or (2) an additional thirty (30) day extension required because the Plan needs additional information from the Claimant (as well as a description of the circumstances requiring the extension and the expected decision date). Any such extension will specifically explain the standards required for receiving the benefit, the unresolved issues preventing a decision, the additional information needed to resolve those issues, and that the Claimant has forty-five (45) days to provide any specified information the Plan needs from the Claimant.

Claim Denials

If a claim is denied, the Plan will notify the Claimant within the time frames stated above. The Plan will also:

- Provide the Claimant the specific reasons the claim was denied;
- Reference the specific Plan provision(s) on which the determination was based;
- Describe any additional material or information needed to complete the claim and an explanation of why the material or information is necessary;
- Describe the Plan's review procedures and the time limits for these procedures plus a statement concerning the Claimant's rights under federal law if the claim is denied;
- 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 or fax that written claim appeal to Plan Administrator Carla Gruetzmacher, IBEW 292 Benefits, 6900 Wedgwood Road North, Suite 425, Maple Grove, MN 55311, (763) 416-6196 (fax), or (763) 493-8830 (phone).

  In response to COVID-19, the Plan adopted temporary rules in response to Department of Labor and Internal Revenue Service guidance providing extended timeframes related to filing claim appeals.

  Starting on March 1, 2020, the deadline to file a claim appeal was suspended during a "Tolling Period" which ends on the earlier of:

  - Sixty (60) days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the "Outbreak Period"); or
  - One (1) year from the date the Eligible Individual was first eligible for relief from a deadline related to filing claim appeals. The earliest date that an Eligible Individual was first eligible for relief from a deadline related to filing a claim appeal was either:
    - March 1, 2020 for claim denials or adverse benefit determinations occurring on or before March 1, 2020. To be in this window, the last day of the applicable deadline must have been on or after March 1, 2020; or
    - The date of a claim denial or adverse benefit determination was after March 1, 2020, but before March 1, 2021.

  The calculation of an individual's Tolling Period and relief from deadlines and suspension of certain requirements is fact-specific and is analyzed as to each Eligible Individual. The Tolling Period may not exceed one (1) year. If the claim denial or adverse benefit determination occurred prior to March 1, 2020, the number of days by which an Eligible Individual is required to take action after the Tolling Period is shortened by the number of days between the date of the claim denial or adverse benefit determination and March 1, 2020.

- 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.

- The Claimant will have the opportunity to submit written comments, documents, records and other information relating to the claim. Neither the Claimant nor the Claimant's representative will have any right to make a personal appearance before the Trustees.

- The Claimant will be provided, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Claimant's claim for benefits.

- The Plan's review will take into account all comments, documents, records, and other information submitted by the Claimant related to the claim, whether or not the information was submitted or considered in the initial benefit determination.

- The review will not afford deference to the initial adverse benefit determination and will be conducted by individuals who were neither the individuals who made the initial adverse benefit determination that is the subject of the appeal, nor the subordinates of such individuals.

- If the appeal relates to an adverse benefit determination that was based at least in part on a medical judgment (including a judgement about whether a particular treatment, drug, or other item is experimental, investigational, or not medically appropriate or necessary), the Plan will consult with a healthcare professional who is trained and experienced in the field of medicine involved in that medical judgement, and who was not consulted in connection with the adverse benefit determination and who does not report to anyone that was consulted.

- Upon request, the Plan will identify any healthcare professional that the Plan consulted in relation to the claim.

- If a health care professional is consulted, the professional will be an individual who is neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal, nor a subordinate of any such individual.

- Before the Plan issues an adverse benefit determination, the Plan will provide you, free of charge and sufficiently in advance of the date on which the notice of benefit determination is required to be provided, with any new or additional rationale or evidence considered, relied upon, or generated by the Plan or those involved with the Plan or the claim, to give you a reasonable opportunity to respond prior to the benefit determination date.

Decision Appeal

- If the Claimant's appeal is for a denial of a claim requiring preauthorization, the Plan will notify the Claimant of its decision on appeal within thirty (30) days of the Plan's receipt of the appeal.

- For all other claims, the Board of Trustees will review the appeal at its next regularly scheduled meeting; however, if the appeal was received by the Fund Office within thirty (30) days of the Board of Trustees meeting, the appeal will be reviewed at the Board's second regularly scheduled meeting following the Plan's receipt of the claim appeal. If special circumstances require, such as the need to hold a hearing, the review of the appeal may be delayed until the Board's third meeting following the request for an appeal. If this extension is required, the Plan will notify the Claimant of the extension and of the special circumstances requiring the extension.

- After a decision is made concerning the appeal, the Claimant will be notified of the decision by the Plan within five (5) business days of the decision being made.

- After a decision is made concerning the appeal, the Board of Trustees will issue a written decision reaffirming, modifying or setting aside the Plan Administrator's former action; the decision to be based upon all evidence in the Trustees' possession, including, but not limited to, that evidence which is presented by the Claimant in support of the appeal.

Claim Appeal Denial

If the Claimant's appeal is partly or completely denied, the claim appeal denial notice will be in writing, will be mailed to the Claimant at the Claimant's last known address and will:

- Tell the Claimant the specific reasons why the appeal was denied;

- Refer to the specific Plan provision(s) on which the determination was based;

- If applicable, describe the Plan's external review procedures and the time limits for those procedures;

- State that the Claimant has the right to bring a civil action under Section 502(a) of ERISA (following external review, if applicable);

- If the Plan relied on an internal rule, guideline, or protocol in making the decision, provide an explanation of such rule, guideline, or protocol;

- State that the Claimant has 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;

- If the claim decision was based on a medical necessity, experimental or investigative treatment exclusion, an explanation of the scientific or clinical judgment relied upon for the determination;

- Include the statement, "You and the Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency"; and

- ♦ If the claim 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 views 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.

External Review Procedures

The Plan must implement an external review process for certain adverse benefit determinations involving items and services within the scope of the surprise billing and cost sharing protections of Sections 716 and 717 of ERISA and the regulations issued thereunder, as provided by the No Surprises Act, within the Consolidated Appropriations Act, 2021 (the "Surprise Billing Provisions," described below).

The Plan's external review process is limited to the review of adverse benefit determinations involving consideration of whether the Plan is complying with the Surprise Billing Provisions. Under the Surprise Billing Provisions, the Plan must generally cover as in-network any out-of-network Emergency Services, non-Emergency Services furnished to you by an out-of-network provider at a Participating Health Care Facility, and out-of-network Air Ambulance Services, subject to any other terms and conditions stated elsewhere in this Summary Plan Description, the Consolidated Appropriations Act, 2021, or the regulations issued pursuant to that act. Generally, under the Surprise Billing Provisions, the cost sharing requirements for these specific out-of-network items and services will be no greater than would apply if the items and services were provided by in-network providers, and cost sharing paid by you for these items and services will apply in the same manner as if the items and services were provided by in-network providers.

The Plan must provide benefits pursuant to an independent review organization ("IRO") decision without delay and regardless of whether the Plan intends to seek a judicial review of the external review decision and unless or until there is a judicial review otherwise.

- ♦ Standard External Review

    - Request for External Review. You may file a request for external review of an adverse benefit determination involving consideration of whether the Plan is complying with the Surprise Billing Provisions within four months after the date you receive notice from the Plan of an adverse benefit determination or final internal adverse benefit determination involving the Surprise Billing Provisions.

- Preliminary Review.

  ► The Plan must complete its preliminary review within five business days following receipt of the external review request to determine whether:

  1. You were Covered Under the Plan at the time the health care item or service in question was requested, or in the case of a retrospective review, if you were Covered Under the Plan at the time the health care item or service was provided;

  2. The adverse benefit determination or final adverse benefit determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan and involves consideration of whether the Plan is complying with the Surprise Billing Provisions;

  3. You have exhausted the Plan's internal appeal process, unless you are not required to do so under the appeals rules; and

  4. You have provided all the information and forms required to process an external review.

  ► Within one business day of completing its preliminary review, the Plan will notify you in writing if:

  1. Your request is eligible for external review;

  2. Your request is complete, but it is not eligible for external review, in which case the Plan will provide you with the reasons it has determined that you are ineligible for external review, along with the contact information for the Department of Labor's Employee Benefits Security Administration (toll-free (866) 444-3272)); or

  3. Your request is not complete, in which case the notice will describe the missing information and materials needed to make the request complete, in which case you may revise your complaint within the four-month external review filing period or within 48 hours after receipt of the notice, whichever is later.

- Referral to IRO. If your request is eligible for external review, the matter will be assigned to an IRO that is accredited by URAC or by a similar nationally recognized accrediting organization to conduct the external review. The Plan has contracted with three IROs and rotates external review assignments among them. The IRO will be required to:

  ► Timely notify you in writing concerning your request's eligibility and acceptance for external review and provide you information on submitting additional information;

  ► Use legal experts, where appropriate, to make coverage determinations under the terms of the Plan;

  ► Notify you of your right to submit additional information in writing for the IRO to consider in making its decision; and

- ► Notify the Plan of and provide to the Plan, within one day of receipt, any additional information you provide regarding your claim appeal, in which case if the Plan reverses its denial and provides coverage or payment based on this additional information, then the external review can be terminated.

- Timely Review All Information and Documentation. In reaching its decision, the IRO will review the claim *de novo* and will not be bound by any prior decisions or conclusions reached during the Plan's internal claims review and appeals procedures. In addition to all of the information and documents timely received, to the extent the information or documents are available and the IRO considers them appropriate, the IRO will consider the following in reaching a decision:

  - ► Your medical records;

  - ► The attending health care professional's recommendation;

  - ► Reports from appropriate health care professionals and other documents submitted by the Plan, you, and your treating provider;

  - ► The terms of the Plan to ensure that any decision reached is not contrary to the Plan's terms unless the terms are inconsistent with law;

  - ► Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government or national or professional medical societies, boards, and associations;

  - ► Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or applicable law; and

  - ► To the extent the final IRO decisionmaker is different from the IRO's clinical reviewer, the opinion of the IRO's clinical reviewer after considering the information described in this notice, to the extent the information or documents are available and the clinical reviewer considers such information or documents appropriate.

- Written Notice of IRO's Final Decision. The IRO will provide written notice of its final external review decision to you and the Plan within 45 days after the IRO receives the initial request for external review. The IRO's notice of its decision will contain:

  - ► A general description of the reason for the request for external review, including the date(s) of service, the health care provider, the claim amount, the diagnosis and treatment codes and their corresponding meanings, and the reason for the previous denial;

  - ► The date the IRO received the assignment to conduct the external review and the date of the IRO's decision;

  - ► References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, that the IRO relied on in making its decision;

- ► A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

- ► A statement that judicial review may be available to you; and

- ► Current contact information, including a phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

- Maintaining Records. After the IRO reaches its final external review decision, the IRO will maintain records of all claims and notices associated with the external review process for six years. The IRO must make all such records available for examination by you, the Plan, and any state or federal oversight agency, upon request, except if such disclosure would violate state or federal privacy laws.

- Reversal of Plan's Decision. The Plan, upon receipt of a notice that a final external review decision reversing the adverse benefit determination or final adverse benefit determination, will immediately provide coverage or payments for the claim.

♦ Expedited External Review

- Request for Expedited External Review. The Plan will allow you to make a request for an expedited external review at the time you receive:

  - ► An adverse benefit determination involving consideration of whether the Plan is complying with the Surprise Billing Provisions if it involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal;

  - ► A final internal adverse benefit determination involving consideration of whether the Plan is complying with the Surprise Billing Provisions if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or jeopardize your ability to regain maximum function; or

  - ► A final internal adverse benefit determination involving consideration of whether the Plan is complying with the Surprise Billing Provisions if it concerns an admission, availability of care, continued stay, or health care item or service for which you received Emergency Services, but you have not been discharged from a facility.

- Preliminary Review. Immediately upon receipt of a request for an expedited external review, the Plan will determine whether the request meets the reviewability requirements and send written notice to you regarding whether you are eligible for an expedited external review.

- Referral to IRO. Upon determining that a request is eligible for expedited external review, following the preliminary review, the Plan will assign an IRO and provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned

IRO as expeditiously as possible, including but not limited to, by email, telephone, or fax.

- Review of Documents. In reaching its decision, the IRO will consider your medical records and other documents to the extent appropriate.

- Notice of Final External Review Decision. The IRO will provide notice of its final expedited external review decision as expeditiously as possible as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review.

  The decision of the IRO will be binding on the Plan as well as you, except to the extent other remedies are available under federal or state law.

Decision Binding on All Involved Persons

- If a claim for benefits is denied, no lawsuit or other action against the Plan or its Trustees may be filed until the review of the matter under the ERISA mandated review procedure set forth in this Article has been completed.

- The decision on review is binding upon all persons dealing with the Plan or claiming any benefit under the Plan, except to the extent that such decision may be determined to be arbitrary or capricious by a court or arbitrator having jurisdiction over such matter.

Circumstances Resulting in Denial or Loss of Benefits

The Trustees or their representatives are authorized to deny payment of a claim. The reasons for denial may include one or more of the following:

- The person on whose behalf the claim was filed was not eligible for benefits on the date the expenses were incurred;

- The Claimant did not file the claim within the Plan time limits;

- The Claimant failed to provide information when requested by the Fund Office;

- The expenses are not covered under the Plan or the expenses for which the Claimant filed the claim were not actually incurred;

- The person 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.);

- 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;

- A third party (such as the driver 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 this Plan (refer to "Right of Subrogation/Reimbursement" in this handbook);

- Another plan was primarily responsible for paying benefits for the expenses (refer to the "Coordination of Benefits" section in this handbook);

- The Trustees reduced or temporarily suspended future benefit payments to a family member in order to recover an overpayment of any benefits payable under this Plan and previously made on that person's behalf;

- The Trustees amended the Plan eligibility rules, reduced or changed Plan benefits;

- Your Employer terminated Contributions to the Fund, either because your Employer did not enter into a successor bargaining agreement requiring Contributions to the Fund, or because the Participation Agreement providing for Contributions to the Fund was terminated;

- The Plan of Benefits was terminated; or

- You or your Eligible Family Members do not meet the regular eligibility requirements of the Plan.

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 that might cause denial of benefits for your claim. If you have any questions about a denied claim, contact the Fund Office.

When Benefits End

Your benefits as an Eligible Employee/Member will end on the first of the following dates to occur:

- The date the Trustees terminate this Plan;

- The date you enter the armed forces of any country on a full-time basis, except as covered under TRICARE;

- 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 you did not meet the eligibility requirements, unless you make Self-Contributions for continued coverage or, if you retire, you make Self-Contributions for continued coverage for Retiree benefits;

- At the end of the last day of the applicable period for which correct and on-time COBRA continuation of coverage payments have been made or on the date of occurrence of any of the events stated in the "Coverage Under COBRA" section, whichever occurs first;

- The date you or any Eligible Individual fails to comply with any condition of participation or Plan rules;

- The date an Eligible Individual makes a fraudulent misstatement regarding eligibility or claims;
- The date your coverage is effectively rescinded; or
- The date of your death.

Your Dependent's coverage will end on the first of the following dates:

- The date the Trustees terminate this Plan;
- The date the Trustees terminate Dependent Benefits under this Plan;
- The date the Dependent Spouse enters the armed forces of any country on a full-time basis;
- The date the Dependent becomes Covered Under the Plan as an Eligible Employee;
- The date the Dependent ceases to be eligible for benefit coverage for reasons other than your death unless timely Contributions to maintain eligibility or for continued coverage are made by or on behalf of the Dependent;
- The date the Dependent fails to comply with any condition of participation or Plan rules;
- The date the Dependent makes a fraudulent misstatement regarding eligibility or claims;
- The date the Dependent's coverage is effectively rescinded;
- For your Spouse, the date of your divorce or legal separation unless your Spouse timely pays the required Contributions for continued coverage;
- For a child who fails to meet this Plan's definition of a Dependent Child, on the date of loss of Dependent status unless Contributions to maintain eligibility or Contributions for continued coverage are made by or on behalf of the Child; or
- In the event of your death, at the end of the last day of the sixth (6^{th}) benefit month following the month in which your death occurred if you have accrued at least twenty-four (24) months of eligibility under this Plan at the time of your death. During this period, your Dependents do not have to pay Self-Contributions to the Fund. After the end of the six-month period, your Eligible Dependents may remain eligible under this Plan by using the remaining balance of your Premium Credit Account. After your Premium Credit Account is exhausted, your Eligible Dependents may make Self-Contributions for continuing eligibility until the first of the following occurs:
    - The date your surviving Spouse remarries;
    - The date your Eligible Dependent or surviving Spouse becomes eligible under any other group health plan; or

- The date your Eligible Dependent or surviving Spouse fails to meet the Plan's definition of Dependent.

♦ If COBRA continuation of coverage payments are being made by or on behalf of the Eligible Dependent, at the end of the last day of the thirty-sixth (36^{th}) month for which a correct and on-time payment was made or on the date of occurrence of any of the events stated in the "Coverage Under COBRA" section, whichever occurs first.

Rescission of Coverage

An Eligible Individual and persons seeking coverage on behalf of an Eligible Individual may not engage in any fraudulent act, practice, or omission in connection with coverage under the Plan or make an intentional misrepresentation of material fact in connection with coverage under the Plan. If an Eligible Individual or a person seeking coverage on behalf of an Eligible Individual engages in such act, practice, omission, or misrepresentation, the Eligible Individual's coverage (including the coverage of any Eligible Dependent in the case of an Eligible Employee or Eligible Retiree and the coverage of the Eligible Employee or Eligible Retiree in the case of an Eligible Dependent) may be retroactively terminated or cancelled.

Retroactive termination or cancellation includes, but is not necessarily limited to, the following:

♦ Any loss, expense, or charge incurred as a result of such act, practice, omission, or misrepresentation will not be covered;

♦ The Eligible Individual (including any Eligible Dependent in the case of an Eligible Employee or Eligible Retiree and the Eligible Employee or Eligible Retiree in the case of an Eligible Dependent) will be required to reimburse the Plan for any claim erroneously paid by the Plan because of such act, practice, omission, or misrepresentation; and

♦ The Trustees of the Plan may treat the Eligible Individual's coverage (including the coverage of any Eligible Dependent in the case of an Eligible Employee or Eligible Retiree and the coverage of the Eligible Employee or Eligible Retiree in the case of an Eligible Dependent) 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 an Eligible Individual's coverage. Intentionally or fraudulently failing to:

♦ Timely update his or her enrollment status;

♦ Report to the Plan:

- His or her divorce;
- His or her legal separation;
- The death of a Dependent; or
- His or her loss of custody of a Dependent Child.

- Satisfy his or her Notification Obligation under this Plan; or

- Honor the Plan's right of subrogation and reimbursement, including the obligation to cooperate with the Plan.

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 provision do not limit the Plan's ability to prospectively terminate your coverage for any other reason.

Notification Obligation

Eligible Individuals must notify the Plan Administrator of any event or change in circumstances that affects:

- Any Eligible Individual's eligibility for coverage under the Plan; or

- Any Eligible Individual's eligibility for payment of any specific claim for benefits.

Eligible Individuals must notify the Fund Office of any such event or change in circumstances in writing within twenty (20) days.

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.

CONTINUATION COVERAGE

Coverage Under COBRA

By federal law you and your Eligible Dependents have the opportunity to continue your health care coverage if coverage is lost for certain reasons. This coverage is called "COBRA Continuation Coverage" and applies to your medical, dental, prescription drug, and vision care. In all cases, the monthly premiums for COBRA Continuation Coverage must be paid through Self-Contributions. You may also continue your life insurance coverage under Minnesota Law for a specified period of time. Weekly income benefits (loss of time), maternity leave benefits, and accidental dismemberment benefits may not be continued. This section covers Continuation Coverage for your medical, dental, prescription drug, and vision care benefits. This section also serves as your Initial COBRA Notice as required by the COBRA Regulations. If you have any questions about continuing any coverage, please call the Fund Office.

Temporary Waiver of COBRA Continuation Coverage Premiums

An Assistance Eligible Individual (as defined below) is not required to pay the premium (including any administrative fee) for COBRA Continuation Coverage for any period of coverage during the period from April 1, 2021 through September 30, 2021 (the "Subsidy Period") and is treated as having paid such premiums for all purposes.

An Assistance Eligible Individual is not eligible for relief from the requirement to pay COBRA premiums during the Subsidy Period described in this section for any month of coverage that begins on or after the earlier of:

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

(b) The earlier of:

  (i) The date following the expiration of the Assistance Eligible Individual's maximum period of COBRA Continuation Coverage; or

  (ii) The date following the expiration of the period of COBRA Continuation Coverage as extended by the rules in the section below, "Temporary Extension of COBRA Election Period."

For periods of COBRA Continuation Coverage following the Subsidy Period, Assistance Eligible Individuals who remain eligible for and continue COBRA Continuation Coverage must pay the applicable COBRA Continuation Coverage premium in accordance with the regular COBRA premium payment rules of the Plan.

Temporary Extension of COBRA Election Period

Any individual who, as of April 1, 2021, would be an Assistance Eligible Individual except for the fact that he or she does not have a COBRA Continuation Coverage election in effect or has discontinued COBRA Continuation Coverage before April 1, 2021, is eligible to elect (or re-elect, as the case may be) COBRA Continuation Coverage during the period from April 1, 2021

through the date that is 60 days after the date that the Plan Administrator provides the individual with the notice described below.

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

Notice to Assistance Eligible Individuals

The Plan Administrator is required to provide Assistance Eligible Individuals and individuals described in the section "Temporary Extension of COBRA Election Period," who become entitled to elect COBRA Continuation Coverage before April 1, 2021, with notice of the availability of and information about the COBRA Continuation Coverage premium, along with the forms required to establish eligibility for premium assistance, no later than 60 days after April 1, 2021.

Requirement to Provide Notice of Eligibility for Another Group Health Plan or Medicare

Any Assistance Eligible Individual who becomes ineligible for the temporary waiver of COBRA Continuation Coverage premiums during the Subsidy Period due to eligibility for another group health plan or Medicare must notify the Plan in accordance with rules established by the Plan Administrator.

Assistance Eligible Individual

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

Events Permitting Continued Coverage

Certain events, known as "Qualifying Events" permit your qualified beneficiaries, which may include you, your Spouse, your Dependent Child(ren) to continue coverage under the Plan if your coverage is lost because of a qualifying event, as indicated below:

- Coverage for an Eligible Employee and the Eligible Dependents of an Eligible Employee may be continued for up to eighteen (18) months if there is a reduction in the Eligible Employee's hours or the Eligible Employee loses his or her job (for any reason other than gross misconduct). Coverage for an Eligible Employee or the Eligible Dependents of the Eligible Employee may be continued for an additional eleven (11) months if the Eligible Employee or the Eligible Dependents of the Eligible Employee are disabled when Continuation Coverage is elected or become Disabled during the first sixty (60) days of Continuation Coverage. A qualified beneficiary must enroll for Continuation Coverage and make correct COBRA Continuation Coverage payments on time to ensure continued coverage.

- Coverage for the Spouse and Eligible Child(ren) of an Eligible Employee may be continued for up to thirty-six (36) months after coverage terminates if, after electing Continuation Coverage, an Eligible Employee and his or her Spouse are divorced or legally separated, a Child no longer meets the definition of a Dependent, an Eligible Employee dies, or becomes entitled to Medicare. A qualified beneficiary can also include a Child born to an Eligible Employee or who is placed for adoption with an Eligible Employee during a period of COBRA Continuation Coverage.

Coverage Options

Eligible Individuals may elect to continue coverage under the entire medical coverage provided by the Plan (medical, prescription drug, dental and vision) upon the occurrence of a COBRA event, except in the case of a Member's termination of employment due to retirement, if such Member has a Premium Credit Account allowing the Member to pay for a period of Retiree Coverage under the Plan with Premium Credits. In that situation, the Member may elect to continue coverage under the Plan through COBRA Continuation Coverage in the same manner as other Eligible Individuals, but only after such Member's Retiree Coverage under the Plan ceases to be covered by the Member's Premium Credits (whether due to the Plan's limitation on the use of Premium Credits to no more than nine months of Retiree Coverage, or due to the Member's exhaustion of his or her Premium Credit Account prior to such nine-month period). An Eligible Employee may not elect to continue coverage for only certain elements of medical coverage provided by the Plan, such as medical and prescription benefits only. However, you may elect separately for life insurance coverage, either along with the Medical Plan or as a separate life insurance-only election.

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

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

A. The month after your employment ends; or

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

If you do not enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of

COBRA coverage. For more information, see https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

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

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

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

Plan Contact Information:

IBEW 292 Benefits
6900 Wedgwood Road North, Suite 425
Maple Grove, MN 55411
(763) 493-8830 or 1-800-368-9045

Notification Responsibilities

Eligible Individuals must notify the Fund Office of a divorce or legal separation or if a Child loses Dependent status. The Fund Office must be notified within sixty (60) days of the date of the qualifying event or within sixty (60) days of the date coverage would end for any person, whichever date is later. In notifying the Fund Office, an Eligible Individual must provide documented evidence of the COBRA Continuation Coverage qualifying event. In the case of a divorce or legal separation, an Eligible Individual must provide a copy of the divorce or legal separation decree or other document verifying the divorce or legal separation is final and the date it became final. In the case of loss of Dependent status, documentation of the loss of Dependent status and the date it occurred must be provided.

An Eligible Employee's Employer must notify the Fund Office within thirty (30) days of any other qualifying event that could cause loss of coverage. An Eligible Employee or Eligible Dependent should always notify the Fund Office when a qualifying event occurs to ensure receipt of all information on Continuation Coverage. An Eligible Employee or Eligible Dependent may be responsible for repaying the Plan if the Plan pays benefits on behalf of a person who is no longer eligible (see "Definitions" for information about Eligible Individuals) and the Fund Office cannot recover the overpaid amounts in any other way.

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

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

- Sixty (60) days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the "Outbreak Period"); or
- One (1) year from the date the qualified beneficiary was first eligible for relief from a deadline related to notification of the Fund Office of a COBRA Continuation Coverage qualifying event. The earliest date that a qualified beneficiary was first eligible for relief from a deadline related to notification of the Fund Office of a COBRA Continuation Coverage qualifying event was either:
    - March 1, 2020 for COBRA Continuation Coverage qualifying events occurring on or before March 1, 2020. To be in this window, the last day of the applicable deadline must have been on or after March 1, 2020; or
    - Upon the occurrence of a COBRA Continuation Coverage qualifying event after March 1, 2020, but before March 1, 2021.

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

You or your Dependent's obligation to notify the Plan of a COBRA Continuation Coverage qualifying event is extended to thirty (30) or sixty (60) days, as applicable, after the end of the Tolling Period, subject to the Proration Rule.

Remember that under the Proration Rule, if a COBRA Continuation Coverage action period was triggered prior to March 1, 2020, the extension periods are shortened by the number of days between the event and March 1, 2020.

Maximum Coverage

Eighteen (18) months is the maximum period of time an Eligible Individual can have COBRA Continuation Coverage if the continued coverage is the result of the Employee's termination or reduction in hours of employment, including in the case of an Eligible Individual who is required to exhaust his or her Premium Credit Account to pay for Retiree Coverage under the Plan prior to becoming eligible to elect COBRA Continuation Coverage. In that situation, the Eligible Individual's maximum COBRA Continuation Coverage period is measured from the date of the loss of Retiree Coverage paid for with Premium Credits, rather than the date of the Employee's termination of employment.

The eighteen (18) month maximum period described above can only be extended if an Eligible Employee or any Eligible Dependent is Disabled when COBRA Continuation Coverage is elected, or becomes Disabled within the first sixty (60) days of this coverage. In this situation, COBRA Continuation Coverage may be extended for a period of up to twenty-nine (29) months. "Disabled" means becoming entitled to disability benefits under the Social Security Act.

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

For example, suppose that the Eligible Employee's death occurs while you are making COBRA Continuation Coverage payments due to reduced hours. The Eligible Dependents had been Covered under COBRA Continuation Coverage for six months before the death. Since the Eligible Employee's death is a qualifying event for his or her Eligible Dependents, the Spouse elects to continue coverage by making COBRA Continuation Coverage payments for Eligible Family Members. The Spouse may continue coverage for an additional thirty (30) months (maximum: thirty-six (36) months minus six (6) months in which COBRA Continuation Coverage payments have already been paid, leaving the remaining thirty (30) months [36 - 6 = 30]).

Then, after your Spouse has continued coverage for an additional fourteen (14) months, one Dependent Child loses Dependent status. This qualifying event entitles the Child to a maximum of thirty-six (36) months of coverage. However, it is reduced by the twenty (20) months of COBRA Continuation Coverage in which payments have already been received (six (6) months of your COBRA Continuation Coverage payments before your death plus fourteen (14) months from your Spouse's Self-Contributions.) That Child may continue coverage for up to sixteen (16) months [36 - 20 = 16].

Another circumstance of extended COBRA Continuation Coverage would involve a situation when the qualifying event is the end of an Eligible Employee's employment and an Eligible Employee became entitled to Medicare benefits less than 18 months before the qualifying event. COBRA Continuation Coverage for qualified beneficiaries other than the Eligible Employee lasts up to thirty-six (36) months after the date of Medicare entitlement. For example, if an Eligible Employee becomes entitled to Medicare eight (8) months before the date on which his or her employment ended, COBRA Continuation Coverage for the Eligible Employee's Dependents can last up to thirty-six (36) months after the date of the qualifying event (Medicare entitlement) (thirty-six (36) months, minus the eight months the Eligible Employee remained employed, leaves twenty-eight (28) months of COBRA Continuation Coverage). The Spouse and Dependent Children may continue coverage via COBRA Continuation Coverage for up to 28 months [36 - 8 = 28].

To take advantage of the rules allowing for extended COBRA Continuation Coverage, you must notify the Fund Office within sixty (60) days of the qualifying event or the date coverage is lost (whichever occurs later) and provide evidence supporting the occurrence of the second qualifying event. As mentioned previously, in the case of a divorce or legal separation you or your Spouse must provide a copy of the divorce or legal separation decree or other documentation evidencing the divorce is final, or in the case of a Dependent losing Dependent status, documentation of the loss of Dependent status.

COBRA Continuation Coverage Procedures and Rules

To ensure maximum coverage, qualified beneficiaries should follow these procedures and rules:

Step 1: The Fund Office will send an Election Notice and Election Form to the last known address of qualified beneficiary upon notification of a qualifying event. The notice explains the right to elect COBRA Continuation Coverage, the due dates, benefit options available, monthly COBRA Continuation Coverage payments required, etc.

Step 2: Qualified beneficiaries should complete the Election Form and send it back to the Fund Office. Individuals electing this coverage must notify the Fund Office of the election within sixty (60) days after the form is sent from the Fund Office or sixty (60) days after coverage would terminate, whichever is later. However, the completed Election Form should be sent as soon as possible since the election date is the date the form is postmarked. COBRA Continuation Coverage is waived if the Fund Office does not receive a completed Election Form within sixty (60) days.

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

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

- Sixty (60) days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the "Outbreak Period"); or
- One (1) year from the date the qualified beneficiary was first eligible for relief from a deadline to elect COBRA Continuation Coverage. The earliest date that a qualified beneficiary was first eligible for relief from a deadline to elect COBRA Continuation Coverage was either:
    - March 1, 2020 for COBRA Continuation Coverage election triggering events occurring on or before March 1, 2020. To be in this window, the last day of the applicable deadline must have been on or after March 1, 2020; or
    - Upon the occurrence of a COBRA Continuation Coverage election triggering event after March 1, 2020, but before March 1, 2021.

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

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

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

Step 3: A qualified beneficiary must make the first payment for COBRA Continuation Coverage within forty-five (45) days after electing Continuation Coverage (e.g., the date the Election Form is returned to the Fund Office). The first COBRA Continuation Coverage payment will be retroactive to the first day on which the qualified beneficiary(ies) lost coverage. You should make your first payment as soon as possible so that you will not have to pay for more than one month at a time.

In response to COVID-19, the Plan adopted temporary rules in response to Department of Labor guidance providing extended timeframes related to COBRA Continuation Coverage.

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

- Sixty (60) days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the "Outbreak Period"); or
- One (1) year from the date the COBRA Continuation Coverage qualified beneficiary was first eligible for relief from the deadline to make the first COBRA Continuation Coverage payment. The earliest date that a COBRA Continuation Coverage qualified beneficiary was first eligible for relief from a deadline related to making the first COBRA Continuation Coverage payment was either:
    - March 1, 2020 for COBRA Continuation Coverage elections occurring on or before March 1, 2020. To be in this window, the last day of the applicable deadline must have been on or after March 1, 2020; or
    - The date of a COBRA Continuation Coverage election after March 1, 2020, but before March 1, 2021.

The date of a COBRA Continuation Coverage election after March The calculation of an individual's Tolling Period and relief from deadlines and suspension of certain requirements is fact specific and is analyzed as to each COBRA Continuation Coverage qualified beneficiary. The Tolling Period may not exceed one (1) year. If the COBRA Continuation Coverage election was made prior to March 1, 2020, the number of days by which a COBRA Continuation Coverage qualified beneficiary is required to take action after the Tolling Period is shortened by the number of days

between the COBRA Continuation Coverage election date and March 1, 2020 (the "Proration Rule").

A COBRA Continuation Coverage qualified beneficiary may now make the first COBRA Continuation Coverage premium payment within the later of 45 days after the end of the Tolling Period or 45 days after the election of COBRA Continuation Coverage.

Remember that under the Proration Rule, if COBRA Continuation Coverage was elected prior to March 1, 2020, the extension periods are shortened by the number of days between the election date and March 1, 2020.

Step 4: A qualified beneficiary must send the correct COBRA Continuation Coverage payment to the Fund Office on time each month. A payment is considered "on time" if it is received in the Fund Office by the first day of the month for which coverage is being paid (the due date) or within thirty (30) days of the due date (the grace period). If the payment is not made on time, then COBRA Continuation Coverage for the qualified beneficiary(ies) will end. The COBRA Continuation Coverage payments may not be made up nor may coverage be reinstated by making future COBRA Continuation Coverage payments.

In response to COVID-19, the Plan adopted temporary rules in response to Department of Labor guidance providing extended timeframes related to COBRA Continuation Coverage.

Starting on March 1, 2020, the deadlines to make the COBRA Continuation Coverage payments were suspended during a "Tolling Period" which ends on the earlier of:

- Sixty (60) days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the "Outbreak Period"); or
- One (1) year from the date the qualified beneficiary was first eligible for relief from a particular month's deadline to make COBRA Continuation Coverage payments. The earliest date that a qualified beneficiary was first eligible for relief from a deadline related to making the first COBRA Continuation Coverage payment was either:
    - March 1, 2020 for COBRA Continuation Coverage payment grace periods ending on or before March 1, 2020. To be in this window, the last day of the grace period must have been on or after March 1, 2020; or
    - The last date of a COBRA Continuation Coverage payment grace period after March 1, 2020, but before March 1, 2021.

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

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

Other rules that affect COBRA Continuation Coverage are:

- A person who becomes covered under another group health care plan after the date of the COBRA Continuation Coverage election is no longer eligible for COBRA Continuation Coverage;

- Each qualified beneficiary who loses coverage because of a qualifying event is entitled to enroll for COBRA Continuation Coverage; and

- The amounts of the monthly COBRA Continuation Coverage payments are determined by the Trustees based on federal regulations. The amounts are subject to change, but not more than once a year unless changes are made in the benefits.

Termination of Continuation Coverage

Continuation Coverage will be terminated for qualified beneficiaries before the end of the applicable eighteen (18) month, twenty-nine (29) month, or thirty-six (36) month period if:

- A correct and on-time COBRA continuation of coverage payment is not sent to the Fund Office;

- The person becomes covered by Medicare after the date Continuation Coverage under this Plan has been elected (except if the person has end stage renal disease or is a disabled active individual as defined by the Social Security Act);

- Coverage results from disability, and the Social Security Administration determines the person is no longer Disabled;

- The I.B.E.W. 292 Health Care Plan no longer provides group coverage to any Employees (members); or

- The person becomes covered under another group health plan after the date Continuation Coverage under this Plan has been elected and the other plan does not limit or exclude coverage for any pre-existing medical condition of the person.

Coverage for Surviving Dependents

The surviving Dependents of an Eligible Employee may continue their coverage based on your status in the Plan at the time of death as explained below:

- **You Were Covered Under the Eligibility During Disability Provision.** Your Dependents will continue to be Covered as stated in the "Eligibility During Disability" section of this handbook. After that period, your Dependents may continue coverage by paying COBRA continuation of coverage payments. Refer to: "Coverage Under COBRA" for more details.

- **You Were Making COBRA Continuation of Coverage Payments.** Your Dependents may continue to make COBRA continuation of coverage payments for up to 36 months, minus the number of months of COBRA continuation of coverage before your death. If your surviving Spouse should die during the time when COBRA continuation of coverage payments have been paid, your Dependents (or their guardian) may continue COBRA continuation of coverage for up to a total of thirty-six (36) months, minus the number of months of COBRA continuation of coverage before your death.

  If your surviving Dependents do not make COBRA continuation of coverage payments, they will not be permitted to make COBRA continuation of coverage payments at any future date.

Coverage for Disabled Qualified Beneficiaries

Special rules apply for Disabled qualified beneficiaries. These rules include the following:

- Qualified beneficiaries who are Social Security disabled at the time of employment termination, reduction in hours, or anytime during the first sixty (60) days of COBRA Continuation Coverage can request that the maximum coverage period be extended eleven (11) months, for a total of up to twenty-nine (29) months.

- Persons must notify the Fund Office of a Social Security disability determination within sixty (60) days of the determination and before the end of the original eighteen (18) month coverage period. In notifying the Fund Office, a qualified beneficiary must provide a copy of the Social Security Administration determination of disability to receive the extension of COBRA Continuation Coverage out to twenty-nine (29) months.

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

  Starting on March 1, 2020, the deadline to request extended COBRA Continuation Coverage due to Social Security disability was suspended during a "Tolling Period" which ends on the earlier of:

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

  - One (1) year from the date the qualified beneficiary was first eligible for relief from a deadline to extend COBRA Continuation Coverage due to Social Security disability. The earliest date that a qualified beneficiary was first eligible for relief from a deadline to request extended COBRA Continuation Coverage due to Social Security disability was either:

    - March 1, 2020 for Social Security disability determinations occurring on or before March 1, 2020. To be in this window, the last day of the applicable deadline must have been on or after March 1, 2020; or

    - Upon the occurrence of a Social Security disability determination after March 1, 2020, but before March 1, 2021.

The calculation of an individual's Tolling Period and relief from deadlines and suspension of certain requirements is fact-specific and is analyzed as to each qualified beneficiary. The Tolling Period may not exceed one (1) year. If the Social Security disability determination occurred prior to March 1, 2020, the number of days by which a qualified beneficiary is required to take action after the Tolling Period is shortened by the number of days between the Social Security disability determination and March 1, 2020 (the "Proration Rule").

You or your Dependent's obligation to notify the Plan of a disability qualifying for a disability extension of COBRA Continuation Coverage is extended to sixty (60) days after the end of the Tolling Period, subject to the Proration Rule.

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

- Payments required for COBRA Continuation Coverage after eighteen (18) months increase to one hundred-fifty percent (150%) of the full cost of coverage.

- A person with extended coverage must notify the Fund Office within thirty (30) days of any final determination made by Social Security that the person is no longer disabled.

SUBROGATION AND REIMBURSEMENT

Introduction

The Plan has a first priority subrogation and reimbursement right 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 does first priority right of subrogation and reimbursement mean? It means that if the Plan pays benefits which are, or may be, 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 does not agree to the Plan's subrogation and reimbursement rules, benefits will not be paid.

For example, the subrogation and reimbursement right may apply if the 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 member in recognition of the fact that the value of benefits provided to each member will be maintained and enhanced by enforcement of these rights.

Subrogation and Reimbursement – Rules for the Plan

The following are the Plan Document rules that apply to the Plan's right of subrogation and reimbursement (the following rules do **not** constitute a Summary Plan Description (SPD) for purposes of this section):

1. 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 the subrogation and reimbursement rights as described in this Subrogation and Reimbursement section. Further, the Eligible Individual or other individual deemed necessary by the Trustees, such as the attorney for the Eligible Individual, will sign a form acknowledging the Plan's subrogation and reimbursement rights prior to payment, or further payment, of benefits. Benefits may not be paid if an acknowledgement form is not on file for the Eligible Individual. Benefits may not be paid if the Eligible Individual or other individual deemed necessary by the Trustees refuses to sign the acknowledgment. The Plan's subrogation and reimbursement rights to benefits paid prior to Plan notice of a subrogation and reimbursement right are not impacted if the Eligible Individual or other individual deemed necessary by the Trustees refuses to sign the acknowledgment. The Plan has the sole discretion to determine, calculate, and/or itemize which benefits paid by the Plan are subject to the Plan's subrogation and reimbursement rights.

2. Constructive Trust or Equitable Lien: The Plan's 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 Eligible Individual 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 subrogation and reimbursement rights, the Plan reserves the right to, among other things, pursue all available equitable action and offset any future benefits payable to the Eligible Individual under the Plan. If the Plan initiates an equitable action for reimbursement, the Plan is seeking to enforce an equitable lien by agreement.

3. 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 right comes first even if the Eligible Individual is not paid for all of their 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.

4. Right to Take Action: The Plan's right of subrogation and reimbursement is an equitable one and applies to all categories of benefits paid by the Plan. The Plan and any other Plan participant 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 subrogation and reimbursement right applies to claims of Eligible Dependents Covered by the Plan regardless of whether such Eligible Dependent is legally obligated for expenses of treatment.

5. 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.

6. No Assignment: The Eligible Individual cannot assign any rights or causes of action they may have against a third party to recover medical expenses without the express written consent of the Plan.

7. 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 any 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.

8. 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 their Injuries, Sickness, or death. Further, the Eligible Individual

must periodically update the Plan regarding the claim and notify the Plan of a settlement prior to reaching a compromise of their claims.

9. 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, and no-fault, uninsured or underinsured motorist insurers), who reimburse, compensate or pay for an 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. This right of subrogation and reimbursement exists regardless of whether the policy of insurance is owned by the Eligible Individual.

10. 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.

11. Attorney's Fees: The Plan will not be responsible for any attorney's 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 attorney's fees or costs.

12. 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 right 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 attorney's fees are awarded to the Eligible Individual's attorney from the Plan's recovery, the Eligible Individual will reimburse the Plan for the attorney's fees.

Trustee Interpretation, Authority, and Right

The Trustees may adopt such rules as they feel are necessary, desirable, or appropriate in the exercise of their fiduciary duty, and they may change these rules and procedures at any time, for any reason.

The Trustees have the authority to interpret the Plan, all Plan documents, rules, and procedures. Their interpretation will be final and binding on all persons 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 such decision is to be upheld unless it is determined to be arbitrary or capricious.

Trustee Authority to Amend and Terminate the Plan

The Trustees have the authority, and reserve the right, to change the eligibility rules and other provisions of the Plan, to amend, increase, decrease or eliminate benefits, and to terminate

the Plan, in whole or in part at any time for any reason. The Trustee's authority to amend, increase, decrease, or eliminate benefits and to terminate the Plan, in whole or part, specifically includes and the Trustees reserve the right to amend, increase, decrease or eliminate and terminate benefits provided to Eligible Retirees and their Eligible Dependents. All benefits of the Plan are conditional and subject to the Trustees' authority to change or terminate them.

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 such purposes. The Trustees will not be liable for the adequacy or inadequacy of such funds.

If there are any excess assets remaining after the payment of all Plan liabilities, those assets will be used for purposes determined by the Trustees according to the Trust Agreement or the Trustees may transfer or apply any remaining property, funds and assets of the Fund in such manner as in their opinion will best effectuate the purposes of the Fund, including turning the assets over to another Employer benefit Trust Fund providing similar benefits to Plan Eligible Individuals. However, any use of such assets may be made only for the benefit of Plan Eligible Individuals who were Covered Under the Plan at the time of the Plan termination.

Release of Information

Subject to the Plan's claims procedures and the Medical Data Privacy Regulations, an Eligible Individual must provide the Fund Office with any verbal or written authorization for release of necessary information relating to any claim you have filed.

An Eligible Individual is also responsible for providing the Fund Office or any claims administrator or insurance company with other information needed to administer the Plan and to process and pay claims. For example, to receive Loss of Time benefits for a work-related disability, you must provide a First Report of Injury (i.e., a doctor's determination of disability) and proof of your Worker's Compensation payments. To ensure proper coordination of benefits, an Eligible Individual must provide information about other group insurance coverage and Explanation of Benefits statements showing the benefits paid by that plan.

Fraud or Misleading Information

Under this Plan, any loss, expense, charge incurred or benefits payments made on behalf of any person, which are made in reliance of fraudulent or misleading information provided to the Plan, will be not be covered. The Trustees may terminate the coverage under the Plan of an Eligible Individual and the Eligible Dependents of an Eligible Individual, on whose behalf the Plan provides benefits in reliance of fraudulent or misleading information and such persons will be ineligible for coverage under the Plan for up to a period of one (1) year.

Worker's Compensation Not Affected

This Plan is not in place of and does not affect any requirement for coverage under any Worker's Compensation law, Occupational Disease 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 an Eligible Individual did not file a claim for benefits under the rules of these laws.

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, (the "Affordable Care Act") 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.

Consolidated Appropriations Act, 2021

The terms and provisions of the Plan will be construed, to the extent possible, to comply with the Consolidated Appropriations Act, 2021, including the No Surprises Act. If it is determined that any term or provision of the Plan cannot reasonably be construed to comply with the Consolidated Appropriations Act, 2021, that term or provision will not be enforced to the extent that it does not comply with the Consolidated Appropriations Act, 2021. A determination that a term or provision of the Plan cannot reasonably be construed to comply with the Consolidated Appropriations Act, 2021, will not affect any other term or provision of the Plan.

GENERAL PLAN INFORMATION

Name and Type of Plan

The name of this plan is the I.B.E.W. 292 Health Care Plan. The Plan is a primary self-insured group health plan that provides medical, dental, vision, safety eyewear, loss of time, maternity leave, accidental death and dismemberment, death, employee assistance, and adoption assistance benefits.

Plan Sponsorship and Determination

This 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.

Eligible Individuals and Beneficiaries may receive from the Fund Office, on written request, information on whether a particular Employer or union is a sponsor of the Plan, and if it is, the sponsor's address.

The names and addresses of the Trustees are shown in the front of this handbook. The address and telephone number of the Fund Office is:

IBEW 292 Benefits
6900 Wedgwood Road North, Suite 425
Maple Grove, MN 55311
(763) 493-8830 or 1-800-368-9045

The Trustees administer the Plan with the help of a salaried administrator. The salaried administrator and other personnel of the Fund office are employees of the Fund. The address of the Plan Administrator is the same as the address for the Fund Office (shown above).

The Plan is maintained under a Collective Bargaining Agreement between Local No. 292 of the International Brotherhood of Electrical Workers, AFL-CIO, and the Minneapolis Chapter of the National Electrical Contractors Association. A copy of the Collective Bargaining Agreement may be obtained by Eligible Individuals and Beneficiaries upon written request to the Fund Office. A copy is also available for examination by Plan Eligible Individuals and Beneficiaries at the Fund Office.

Service of Legal Process

The name and address of the agent who the Trustees have appointed for service of legal process is:

Carla Gruetzmacher, Plan Administrator
IBEW 292 Benefits
6900 Wedgwood Road North, Suite 425
Maple Grove, MN 55311

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

Source of Contributions and Plan Participation

The Plan 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 Plan. The amounts of those Contributions are 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 Fund also receives Contributions from Employers who have entered into Participation Agreements with the Trustees to provide coverage for their Employees who are not 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 Plan 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 these Collective Bargaining Agreements or Participation Agreements and if their Employers make the required Contributions to the Plan on their behalf.

The Plan 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.

Accumulation of Assets and Payments of Benefits

Employer Contributions and Employee, Retiree, and Dependent Self-Contributions are received and held in trust by the Trustees pending the payment of benefits, insurance premiums, and administrative expenses.

All benefits paid from this Plan are self-insured except for accidental death and dismemberment and life insurance benefits. Accidental death and dismemberment and life insurance benefits are provided by policies issued by Union Labor Life Insurance Company. 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 Fund. Benefits payable by the Fund are limited to the Fund assets available for paying benefits.

Plan Year

The Plan year is May 1 through April 30. Records are maintained on a Calendar Year basis, with a December 31 year end.

Employer Identification Number

The employer identification number (EIN) assigned to the Plan's Trust Fund by the Internal Revenue Service is 41-1384754.

Plan Number

The Plan number the Trustees have assigned to this Plan is 501.

Preferred Provider Network Directory

A directory of the providers in the Plan's medical preferred provider network is at uhss.welcometouhc.com.

Your Rights Under ERISA

As an Eligible Individual in the I.B.E.W. 292 Health Care Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan Eligible Individuals are entitled to:

- **Receive Information About the 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 Pension and Welfare Benefit 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 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 Eligible Individual with a copy of this summary annual report;

- **Continue Group Health Plan Coverage.** Eligible Individuals may have the right to continue health care coverage if there is a loss of coverage under the Plan as a result of qualifying event. Eligible Individuals may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing COBRA continuation coverage rights.

  Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under a group health plan, if an Eligible Individual has creditable coverage from another plan. A group health plan or health insurance insurer must provide a certificate of creditable coverage, free of charge, an Eligible Individual: 1) loses coverage under the Plan; (2) becomes entitled to elect COBRA continuation coverage; or 3) when COBRA continuation coverage ceases, an Eligible Individual requests it before losing coverage, or up to twenty-four (24) months after losing coverage. Without evidence of creditable coverage, an Eligible Individual may be subject to a preexisting condition exclusion for twelve (12) months (eighteen (18) months for late enrollees) after the Eligible Individual's enrollment date for coverage;

- **Prudent Actions by Plan Fiduciaries.** In addition to creating rights for Eligible Individuals, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of the Eligible Individuals and Beneficiaries. No one, including your employer, your union, or any other person, 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; and

- **Enforce Your Rights.** If an Eligible Individual's claim for a welfare benefit is denied or ignored, in whole or in part, the Eligible Individual has 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 an Eligible Individual can take to enforce the above rights. For instance, if an Eligible Individual requests a copy of plan documents or the latest annual report from the plan and does not receive them within 30 days, an Eligible Individual may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay up to $110 a day until the Eligible Individual receives the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If an Eligible Individual has a claim for benefits which is denied or ignored, in whole or in part, the Eligible Individual 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 domestic relations order or 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 discriminated against an Eligible Individual for asserting his or her rights, an Eligible Individual 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 an Eligible Individual is successful the court may order the person sued to pay these costs and fees. The court may order an Eligible Individual to pay these costs and fees, for example, if it finds the claim is frivolous.

Assistance with Your Questions

An Eligible Individual should contact the Plan Administrator to discuss any questions about the Plan. If an Eligible Individual has any questions about this statement or about his or her 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, Employee Benefits Security 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.

How to Obtain Plan Materials

You can read the material listed in the above section by making an appointment at the Fund Office during normal business hours. This same information can be made available for your examination at certain locations other than the Fund Office. The Fund Office will inform you of these locations. Also, copies of the material will be mailed to you if you send a written request to the Fund Office. There may be a reasonable charge for copying some of the materials. Before requesting material, call the Fund Office to find out the cost. If a charge is made, your check must be attached to your written request for the material. The Fund Office address and phone number are shown on the front cover of this handbook.

Gender and Number

Any reference to the masculine gender in this document also applies to the feminine gender and vice versa, unless the context requires otherwise. Any reference to the singular may also

apply to the plural and vice versa, unless the context requires otherwise or the result would be unreasonable.

Examinations

The Trustees have the right to have a Physician examine a person 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, subject to the Plan's Medical Data Privacy rules.

Free Choice of Physician

An Eligible Individual has free choice of any legally qualified Physician, Hospital or other provider or entity providing service or supplies considered to be Covered Expenses.

Governing Law

This Plan is created and adopted 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 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.

Legal Proceedings

- The Plan is maintained for the exclusive benefit of the Plan's Eligible Employees, Eligible Retirees and Eligible Dependents.

- No action at law or in equity may be brought to recover under the Plan until the claim appeal procedures under the Plan have been exhausted in accordance with the requirements of the Plan, nor may such action be brought at all unless brought within two years from the expiration of the time within which proof of loss is required to be furnished.

- In the event a claim for benefits has been denied, no lawsuit or other action against the Fund or its Trustees or Administrator may be filed until the matter has been submitted for review under the ERISA mandated claims review procedures set forth in this Summary Plan Description and all claim appeal procedures under the Plan have been exhausted. The decision on review will be binding upon all persons dealing with the Plan or claiming any benefit under the Plan, except to the extent that such decision may be determined to be arbitrary or capricious by a court or arbitrator having jurisdiction over such matter.

- This provision, permitting court action, may not be interpreted to extend or reinstitute any claim or cause of action which has expired under the time limits set forth in the Trust Agreement, or in any Plan document or regulations of the Trustees or under any statute if such time limit has already expired.

- This "Legal Proceedings" section does not apply to matters covered, or purportedly covered by the terms of any insurance policy procured by the Trustees.

Time Limitation

If any time limitation of the Plan, with respect to giving notice of claim, furnishing proof of claim or loss or the bringing of an action at law or in equity, is less than that permitted by any law to which this Plan is subject, such limitation is hereby extended to agree with the minimum period permitted by such law.

- Medical benefits will be payable only for Covered Expenses which are Medically Necessary and which are required in connection with the care and treatment of an Eligible Individual as a result of non-occupational Injury or Sickness.

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

TELEPHONE NUMBERS AND WEB ADDRESSES

Fund Office	763-493-8830 or 1-800-368-9045	www.ibew292benefits.org
Sav-Rx	1-866-233-IBEW (4239)	www.savrx.com
Delta Dental	651-406-5900 or 1-800-533-9536	www.deltadental.com
Optum	866-248-4096	https://www.liveandworkwell.com/
Vision Service Plan (VSP)	1-800-877-7195	www.VSP.com

DEFINITIONS

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

BENEFICIARY. An individual who is not and was not an Employee or former Employee or Retiree, but who is or may in the future be, by reason of the individual's relationship, eligible for benefits under the Plan.

BODY MASS INDEX ("BMI"). A number which is a measure of weight for height and can be calculated by a Physician to indicate an individual's weight status.

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

CHILD. For purposes of the Plan, a person who is:

- Your biological child;

- 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 obligation;

- Any foster child placed with you by an authorized placement agency or court;

- Any stepchild of yours, meaning any child of your current Spouse from whom you are not legally separated:

  - Who was born to such Spouse;

  - Who was legally adopted by such Spouse;

  - Who has been placed for adoption with such Spouse; or

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

- Any unmarried child for whom you are responsible for providing health care coverage according to the terms of a court decree called a Qualified Medical Child Support Order ("QMCSO") with which you and the Plan are obligated to comply.

COLLECTIVE BARGAINING AGREEMENT(S). Any Collective Bargaining Agreement(s) in force and effect between the Union and an Employer or Employers of an Employer's Association which require the Employers to make Contributions to the Plan on behalf of their Employees for work performed within the jurisdiction of the Union, together with any modifications or amendments of such Collective Bargaining Agreements.

CONTRIBUTIONS.

- Payments made to the Fund by Employers pursuant to a Collective Bargaining Agreement (or other agreement between the Employer and the Plan) on behalf of their Employees for hours worked by their Employees and also Employee payments to the Plan as required by such Agreements; and

- Self-Contributions as defined below.

COVERED OR COVERED UNDER THE PLAN. This term means a person is eligible to receive the Plan benefits which are applicable 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 Fund on the Employee's behalf. Work performed within the jurisdiction of another I.B.E.W. local union for which Contributions may be transferred under reciprocal agreement.

COVERED EXPENSES; COVERED MEDICAL EXPENSES. The Reasonable, Customary and Medically Necessary Charges incurred by an Eligible Individual upon the recommendation and approval of the attending Physician for services and supplies required for treatment of the Eligible Individual as a result of a non-occupational Injury or Sickness and for which Plan benefits are payable, subject to the Schedule of Benefits and other Plan provisions.

DENTIST. A person who is currently licensed to practice dentistry by the governmental authority having jurisdiction over the licensure and practice of dentistry.

DEPENDENT**.** For purposes of the Plan, a person who is:

- The Spouse of an Eligible Employee or Eligible Retiree while not legally separated from such Employee or Retiree. The Plan may require that an Employee or Retiree provide a certified copy of his or her marriage certificate before any benefits are paid for a Dependent Spouse.

    - Effective January 1, 2018, employed Spouses who are eligible to enroll in Qualifying Employer Health Care Coverage through their employer for a cost of less than $250 per month for the lowest cost employee-only coverage option are required to enroll in such coverage in order to be eligible for Medical Coverage under the Plan.

- An Eligible Employee’s or Eligible Retiree’s Child who is less than 26 years of age.

- Any grandchild of an Eligible Individual or Eligible Retiree, provided that:

    - The Eligible Employee or Eligible Retiree has been appointed the legal guardian of the grandchild; or a parent of the grandchild is: (i) a Dependent Child under this Plan; (ii) age 19 but less than age 26, and such Child is a registered full-time student in an accredited post-secondary school, college or university or in a vocational or technical trade school or institute and is dependent upon the Employee or Retiree for the major portion of the grandchild’s support and maintenance, as defined above; and

(iii) unmarried, and provided also that the Eligible Employee or Eligible Retiree, the parent of the grandchild, and the grandchild all reside in the same household;

- The grandchild is not eligible for coverage through an employer of the grandchild or the grandchild's parents.

Eligibility for the grandchild will terminate immediately if any of the above requirements are no longer met.

The value of Plan benefits provided to or premiums for individuals who are not tax dependent individuals is taxable income to the Employee or Retiree.

DEPENDENT BENEFITS. The benefits provided under this Plan for Eligible Dependents of Eligible Employees and Eligible Retirees.

DISABLED. See Totally Disabled.

ELECTIVE SURGERY. Elective Surgery means a non-Emergency surgical procedure that does not need to be performed immediately.

ELIGIBLE DEPENDENT. Any Dependent who is eligible to receive the Plan benefits provided for Dependents of Eligible Employees and Eligible Retirees. In the context of benefit descriptions, an Eligible Dependent means an Eligible Dependent who is enrolled and Covered Under the Plan.

ELIGIBLE EMPLOYEE. Any Employee who has met the eligibility requirements specified in this Plan for being Covered Under the Plan and who is therefore entitled to receive Plan benefits provided for Employees.

***ELIGIBLE FAMILY MEMBER*.** An Eligible Employee or an Eligible Retiree or person in the Employee's or Retiree's family or household who meets the definition of a Dependent.

***ELIGIBLE INDIVIDUAL*.** An Eligible Employee, Eligible Retiree, or Eligible Dependent.

ELIGIBLE RETIREE. A Retiree who has met the eligibility requirements specified in this Plan for being Covered Under the Plan and who is entitled to receive the Plan benefits provided for Retirees.

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

- Placing the health of the person (or in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

EMERGENCY SERVICES.

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

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

EMPLOYEE.

- A Member;

- All those persons who are represented in collective bargaining by the Union and who are employed by an Employer who has agreed to make Contributions all or a portion of the payments to the Fund on their behalf;

- Individuals employed by the following Eligible Employers listed below provided that:

    - The Employee satisfies the requirements in the applicable Participation Agreement between the Plan and the Employee's Employer;

    - The Employee has been employed at least one (1) month;

    - The Employee is not participating in a health care plan established as a result of collective bargaining; and

    - Participation of such employees is in accordance with all applicable regulatory law and will not impair the tax exempt status of the Plan. The Trustees reserve the right to refuse or terminate participation of any such Employees if, in their sole discretion, such action is necessary or appropriate to preserve the Plan's integrity or tax exempt status.

- Individuals employed by I.B.E.W. Local Union No. 292, provided the Union has made written application to the Trustees requesting participation in the Plan for coverage for such Individuals who are not covered under a Collective Bargaining Agreement, and the Trustees have approved such application for participation (see definition of "Participation Agreement");

- Individuals employed by the Minneapolis Chapter, National Electrical Contractors' Association, Inc. which has made written application to the Trustees requesting participation in the Plan for coverage for its Employees who are not covered under a Collective Bargaining Agreement, provided the Trustees have approved such application for participation (see definition of "Participation Agreement");

- Individuals employed by an Employer which has made written application to the Trustees requesting participation in the Plan for coverage for such individuals who are not covered

under a Collective Bargaining Agreement, if the Trustees have approved such application for participation (see definition of "Participation Agreement");

- Individuals employed by the Fund; and

- Individuals who are employed by an Employer member of the Minneapolis Chapter, National Electrical Contractors' Association which has made written application for coverage for its Employees who are not covered under a Collective Bargaining Agreement, provided the Trustees have approved such application for participation (see definition of "Participation Agreement").

EMPLOYER'S ASSOCIATION. The Minneapolis Chapter, National Electrical Contractors Association, Inc. which is a party to a bargaining agreement requiring Contributions to the Fund and which is entitled to appoint Employer Trustees pursuant to the Trust Agreement.

EMPLOYEE BENEFITS. Benefits provided by the Plan for Eligible Employees or members.

***EMPLOYER OR CONTRIBUTING EMPLOYER*.**

- Any person, firm, association, sole proprietorship, partnership or corporation who on the Effective Date of this Plan, entered, or in the future enters, into Collective Bargaining Agreements that require Contributions be made to the Fund at the same rate of Contribution as other Employers currently contributing or required to contribute to the Fund;

- The Employer's Association in its capacity as an Employer of Employees not covered by a Collective Bargaining Agreement, provided such Employer's Association has a valid Participation Agreement in effect with the Trustees;

- The Union in its capacity as Employer of Employees not covered by Collective Bargaining Agreements provided the Union has in effect a valid Participation Agreement with the Trustees, and further provided that the Union does not have a voice in the selection of any Employer Trustee;

- Any other employer of Employees not covered by Collective Bargaining Agreements, provided such Employer has in effect a valid Participation Agreement with the Trustees, and further provided that such Employer does not have a voice in the selection of any Trustee;

- Employers who are members of the Employer's Association, provided such Employer has a valid Participation Agreement with the Trustees; and

- The Trustees with respect to full-time Employees of the Fund.

EXPERIMENTAL OR INVESTIGATIVE. For the purposes of this Plan, the use of any treatment (which includes use of any treatment, procedure, 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 (including, but not limited to, holistic healing);

- 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

- The use is not supported by reliable evidence which shows that, as applied to a particular condition, it:

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

    - Has a definite positive effect on health outcomes;

    - 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

    - Is at least as effective as a standard means of treatment in improving health outcomes, or is usable in appropriate clinical contexts in which standard treatment is not employable.

Reliable evidence includes only:

- Published reports and articles in authoritative medical and scientific literature;

- 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;

- Compilations, conclusions, and other information which is available and may be drawn or inferred from the aforementioned reports, articles, protocols or written informed consent; and

- Publications listing procedures approved by the Health Care Financing Administration.

Consideration may be given whether:

- 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;

- Reliable evidence shows that the treatment is the subject of ongoing Phase I, II, or Ill clinical trials and is 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;

- 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

- 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.

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

FUND OR TRUST FUND. This term refers to I.B.E.W. 292 Health Care Plan and the Trust Fund created pursuant to the Amended Agreement and Declaration of Trust.

HOME HEALTH AGENCY. A public agency or private organization, or a subdivision of such an agency or organization, which meets all of the following requirements:

- It is primarily engaged in providing skilled nursing services and other therapeutic services in the homes of its patients;
- It has policies (established by a group of professional personnel associated with the agency or organization) governing the services that it provides;
- It provides for the supervision of its services by a Physician or a registered professional nurse;
- It maintains clerical records on all of its patients;
- It is licensed according to the applicable laws of the state in which the Eligible Individual receiving the treatment lives and of the locality in which it is located or in which it provides services; and
- It is eligible to participate in Medicare.

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 persons suffering from a terminal medical condition. This may be a free standing facility or a specifically designated area engaged solely in providing care for the terminally ill within a large organization. The agency or organization must:

- Be eligible to participate in Medicare;
- Have an interdisciplinary group of personnel that includes the services of at least one Physician and one R.N.;
- Maintain clerical records on all patients;
- Meet the standards of the National Hospice Organization; and
- Provide, either directly or under other arrangement, the "core services" listed in this handbook as Covered Expenses for the Hospice Care Program.

HOSPITAL. An institution which is engaged primarily in providing medical care and treatment to sick and injured persons on an inpatient basis at the patients' expense and which meets all the requirements listed below:

- It is a hospital, a psychiatric hospital or a tuberculosis hospital as those terms are defined in Medicare which is qualified to participate in Medicare and to receive Medicare payments; or

- It is a hospital accredited by the Joint Commission on Accreditation of Health Care Organizations; or

- It is an institution which: (a) 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) provides on-the-premises 24-hour-a-day nursing services by or under the supervision of RNs, and (c) is operated continuously with organized facilities for operative surgery on the premises; or

- With respect to treatment of Mental or Nervous Disorders, it is a community mental health center or mental health clinic approved or licensed by the authorized state agency; or

- With respect to an emotionally handicapped Child, it is a licensed residential treatment facility; or

- 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 of Minnesota under the diagnosis or recommendation of a Doctor of Medicine or under court order.

A Hospital is not an institution which is primarily a clinic or, other than incidentally, a place for rest, for the aged, for drug addicts, for alcoholics or a nursing or convalescent home or similar establishment.

ILLNESS/SICKNESS. Illness, sickness, or disease which occurs while Covered Under the Plan.

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

INJURY. Means a bodily injury which requires treatment by a Physician. It must result in loss independently of Sickness and other causes. To be Covered under the Plan's medical coverage, an injury also cannot be work-related unless there is an applicable Plan provision that states otherwise. (Occupational injuries may be Covered by this Plan if you have signed a subrogation and reimbursement agreement and have been denied worker's compensation benefits. Contact the Fund Office if you have questions about coverage for occupational injuries.)

INTENSIVE OUTPATIENT DAY TREATMENT. An intensive ambulatory service provided in a licensed mental health non-residential setting, by a multi-disciplinary team consisting of psychiatry, psychology and other supportive therapies as indicated by patient need. This level of care includes diagnostic evaluation, individual, group and family therapies as indicated. This

level of care will provide a level of structure necessary to stabilize acute psychiatric crisis and/or assist individuals with chronic mental disorders. The program will typically have available a minimum of fifteen (15) hours of therapeutic involvement per week.

INVESTIGATIVE. See Experimental or Investigative.

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 based on the opinion of a qualified medical professional, to identify or treat an Eligible Family Member's Injury or Sickness and which:

- Are consistent with the symptoms or diagnosis and treatment of the Eligible Individual's condition, disease, ailment or Injury;
- Are appropriate according to and are consistent with accepted standards of community medical practice;
- Are not solely for the convenience of the Eligible Individual (including his or her family or caregiver), Physician or Hospital;
- Are the most appropriate and can be safely provided to the Eligible Individual;
- Are not deemed to be Experimental or Investigative; and
- Are not furnished in connection with medical or other research.

Benefits will be denied for services that are not considered to be medically necessary based on the above criteria.

MEDICARE. The Health Insurance for the Aged Program under the Title XVIII of the Social Security Act as the program currently exists and as it may later be amended.

MEMBER. A Bargaining Unit Employee who is working under the Inside Agreement.

***MENTAL OR NERVOUS DISORDER*.** A neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind, regardless of any physiological or traumatic cause or origin of such condition.

***MOTOR VEHICLE*.** Any registered or unregistered, licensed, or unlicensed, on-road or off-road automobiles, trucks, motorcycles, recreational vehicles, or motor homes.

***ORAL SURGERY*.** Any procedure performed on the teeth, mouth or jaw which may be performed by a DDS or Oral Surgeon.

PALLIATIVE CARE. Treatment which is provided to a terminally-ill person for the purpose of relieving or alleviating symptoms without curing.

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PARTIAL HOSPITALIZATION. An intensive ambulatory service provided in a licensed acute care setting by a multi-disciplinary team consisting of psychiatry, nursing, social work and psychology, with occupational and other supportive therapies available when indicated by

patient need. The program will have available a minimum of six hours of therapeutic involvement daily, five days a week.

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

PARTICIPATION AGREEMENT. A written agreement between the Trustees and an Employer in which the Trustees approve the Employer's participation in the Plan and the Employer agrees to make and the Trustees agree to accept Contributions to the Fund on behalf of the Employer's Employees who are not members of the bargaining group. The Trustees will, by appropriate action, determine the Employer's Contribution rate.

PERIOD OF CRISIS. A period during which a terminally-ill person 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.

PHYSICIAN. A legally qualified physician or surgeon who is a Physician of Medicine (M.D.), a Physician of Osteopathy (D.O.), a Physician of Chiropractic (D.C.), a Physician of Dentistry (D.D.S .), or a Physician of Podiatry (D.P.M.). Any practitioner of the healing arts other than the Employee or Dependents of the Employee licensed to practice in his or her state and providing services within the scope of that licensing.

PLAN OR BENEFIT PLAN OR PLAN OF BENEFITS. The self-funded program of health and welfare benefits described in this handbook established and amended from time to time by the Board of Trustees pursuant to the Trust Agreement.

QUALIFYING EMPLOYER HEALTH CARE COVERAGE. Coverage that:

- Is insured, or self-insured, by the employer of a Spouse, and subject to regulation by state or federal agencies, such as the U.S. Department of Labor or Internal Revenue Service; and

- Provides standard benefits equal to the Bronze level plan of benefits for medically-necessary hospitalization, surgery, outpatient medical treatment and prescription drug coverage.

***REASONABLE AND CUSTOMARY OR REASONABLE AND CUSTOMARY CHARGE*.**

- With respect to medical expenses incurred by an Eligible Individual as a result of a non-occupational Injury or Sickness, the Plan's maximum allowable expense for a charge by a Physician or any other provider of medical services or supplies is the applicable percentage as specified under the "Schedule of Benefits", provided that the Plan may review and compare the charge with the charges made by other Physicians and providers of medical services or supplies for similar services or supplies in the locality concerned to individuals of similar age, sex, circumstances and medical condition.

- With respect to dental expenses incurred by an Eligible Individual, the Plan's maximum allowable expense for a charge by a Dentist for services and supplies rendered for the treatment of a dental condition is the applicable percentage as specified under the "Schedule of Benefits", provided that the Plan may review and compare the charge with

the charges made by other Dentists for services and supplies customarily employed for the treatment of a particular dental condition in the locality concerned, provided such services and supplies are rendered in accordance with accepted standards of dental practice and are rendered by a licensed D.D.S.

- With respect to orthodontia expenses incurred by an Eligible Individual, the Plan's maximum allowable expense for a charge by an orthodontist for services and supplies rendered for the treatment of an orthodontic condition as specified under the Schedule of Benefits, provided that the Plan may review and compare the charge with the charges made by other orthodontists for services and supplies customarily employed for the treatment of a particular orthodontic condition in the locality concerned, taking into consideration the age of the patient and those types of orthodontic services which are required for the specific condition of the individual on whose behalf the charges are incurred, provided such services and supplies are rendered in accordance with accepted standards of orthodontic practice and are rendered by a D.D.S. licensed to practice orthodontia.

- A Reasonable and Customary Charge will not exceed charges actually incurred.

RESPITE CARE. Short-term, inpatient care provided to a terminally-ill person only when necessary to relieve family members caring for him or her.

RETIREE OR RETIRED EMPLOYEE (OR MEMBER). A person who was an Eligible Employee under this Plan on the day preceding the date of retirement and who is now retired either under the retirement provisions of a pension plan negotiated or sponsored by the I.B.E.W. or under the provisions of the Social Security Program, provided that the Employer of the Employee is a party to the Collective Bargaining Agreement between the Employer's Association and the Union at the time the Eligible Employee retires, and the individual has been Covered under the Plan for at least 2 out of the last 5 years and entered the Retiree Plan directly from Covered Employment.

ROOM AND BOARD CHARGES. All charges made by a Hospital on its own behalf for room, board, general duty nursing as well as any other charges which are regularly made by the Hospital as a condition of confinement in the class of accommodations occupied by the Eligible Individual. This does not include charges for professional services of Physicians, private duty nurses or charges for intensive nursing care.

***SELF-CONTRIBUTIONS*.**

- Payments made by Bargaining Unit Employees and Non-Bargaining Unit Employees of Employers signatory to the Inside Construction and Maintenance Collective Bargaining Agreement for the purpose of maintaining eligibility;

- Payments made to the Plan on behalf of Bargaining Unit Employees and Non-Bargaining Unit Employees of Employers signatory to a Collective Bargaining Agreement other than the Inside Construction and Maintenance Collective Bargaining Agreement for the purpose of maintaining;

- Payments made to the Plan by Eligible Retirees and surviving Spouses of Eligible Retirees for the purpose of maintaining eligibility or for defraying the additional cost of an elected HCO; and

- Payments made to the Fund for Continuation Coverage under COBRA by Employees, Retirees and Dependents for the purpose of maintaining their coverage under the Plan (see "Continuation Coverage").

SKILLED CARE. Services that are Medically Necessary and provided by registered nurses or other approved Providers. A service is not considered skilled care simply because it is performed by, or under the direct supervision of a registered nurse or other approved provider. If a service can be safely and effectively performed by a non-medical person or self-administered without the direct supervision of a registered nurse or approved provider, the service is not regarded as skilled care, whether or not a registered nurse or approved provider provides the service. The unavailability of a competent individual to provide non-skilled care does not make the service skilled when provided by a registered nurse or approved provider.

***SKILLED NURSING FACILITY*.** A lawfully operating institution, or a distinct part of an institution, which complies with all licensing and other legal requirements and which meets all of the following criteria:

- It is primarily engaged in providing in-patient skilled nursing care, physical restoration and rehabilitation services and related services for patients who are convalescing from Injury or Sickness and who require medical or nursing care to assist the patients in reaching a degree of body functioning to permit self-care in essential daily living activities;

- It provides 24-hour-a-day supervision by one or more Physicians or one or more registered graduate nurses (R.N.'s) responsible for the care of its in-patients;

- It provides 24-hour-a-day nursing services by licensed nurses under the supervision of an R.N., and it has an R.N. on duty for at least eight hours a day;

- Every patient is under the supervision of a Physician;

- It has available at all times the services of a Physician;

- It maintains daily medical records on all patients;

- It provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;

- It has a utilization review plan;

- It has a transfer agreement with one or more Hospitals;

- It is eligible to participate in Medicare; and

- It is not, other than incidentally, an institution which is a place of rest, a nursing home, 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.

***SPOUSE*.** Spouse means an individual who is the legally recognized spouse of the Eligible Employee or Eligible Retiree under the laws of the state in which the marriage or civil union was established. For this purpose, a legal civil union is considered a legal marriage. A certified copy of your marriage certificate or other documentation substantiating status as a spouse may be required to be on file at the Fund Office before claims for your spouse will be processed*.*

SUMMARY PLAN DESCRIPTION (SPD). This handbook, which is also the Plan document.

***SUNGLASSES*.** Any prescription or nonprescription lenses that are permanently tinted unless the tint is prescribed for therapeutic purposes.

TERMINAL ILLNESS. A person's medical prognosis indicates a life expectancy of twelve months or less.

***TMJ*.** Conditions including but not limited to temporomandibular joint syndrome, craniomandibular disorders, and other conditions of the joint linking the jaw bone and the skull, along with the complex of muscles, nerves and other tissues related to that joint.

***TOTALLY DISABLED, TOTAL DISABILITY OR DISABLED*.** In all areas except the section on life insurance, this term refers to:

- An Eligible Employee who is completely unable to perform each and every duty of his occupation or employment because of an Injury or Sickness; or

- An Eligible Dependent or Eligible Retiree who is completely unable to perform the normal activities of a person of like age and sex in good health because of a non-occupational Injury or Sickness.

The Eligible Employee's attending Physician must determine an Injury or Sickness as a disability by an attending Physician's statement.

In regard to life insurance, Totally Disabled, Total Disability or Disabled means that because of an Injury or Sickness the Eligible Individual is completely and continuously unable to perform any work or engage in any occupation.

TREATMENT FACILITY. A rehabilitation facility for the treatment of individuals suffering from alcoholism or drug addiction. To be considered an approved treatment facility under this Plan, the facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or meet certain requirements specified by the Trustees.

TRUST AGREEMENT. The Amended Agreement and Declaration of Trust establishing the I.B.E.W. 292 Health Care Plan.

TRUSTEES; BOARD OF TRUSTEES. The individuals responsible for the operation of the I.B.E.W. 292 Health Care Plan according to the terms of the Trust Agreement, together with such Trustees' successors. Trustees appointed by the Employer's Association are Management Trustees; Trustees appointed by the Union are Labor Trustees.

UNION. This term refers to I.B.E.W. 292.

Please note that use of the term “you” or “your” refers to the Eligible Employee or Eligible Retiree as applicable.

MEDICAL DATA PRIVACY

Introduction

The United States Department of Health and Human Services has adopted regulations governing the Plan's use and disclosure of your health information. The regulations arose from the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH). While the Plan has always taken care to protect the privacy of your health information, the regulations require the Plan to adopt formal procedures and to tell you about these procedures in this booklet. The information below discusses ways in which the Plan uses and discloses your health information.

Under HIPAA and HITECH, 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 person or office to contact for further information about the Plan's privacy practices.

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) 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 use, disclose, and request PHI, to the extent practicable, in a limited data set, or if needed, in the minimum amount 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 Regulations.

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.

Use of PHI for Payment and Health Care Operations

Payment includes the Plan's activities to obtain premiums, Contributions, self-payment, 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 providing reimbursement for providing health care that has been provided. These activities include but are not limited to the following:

1. Determining eligibility or coverage under the Plan;

2. Adjudicating claims for benefits (including claim appeals and other benefit payment disputes);

3. Subrogation;

4. Coordination of Benefits;

5. Establishing self-payments by persons Covered under the Plan;

6. Billing and collection activities;

7. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to Covered persons' inquiries about payments;

8. Obtaining payment under stop-loss or similar reinsurance;

9. Reviewing whether claims are payable under the Plan, including whether they are Medically Necessary, Reasonable and Customary, or otherwise payable;

10. Reviewing coverage under the Plan, appropriateness of care, or justification of charges;

11. Utilization review, including precertification, preauthorization, concurrent review and retrospective reviews;

12. 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

13. Reimbursement to the Plan.

Health Care Operations can include any of the following activities. While the Plan does not currently use or release PHI for all of these activities, it may do so in the future to perform health care operations of the Plan:

1. Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines as long as general knowledge is not the primary purpose of these studies; population based activities relating to improving health or reducing health care costs, protocol development, case management and care

coordination, contacting health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;

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

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

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

5. Planning and development, such as conducting cost-management and planning related analyses relating to managing and operating the Plan (including formulary development and administration, development or improvement of methods of payment or coverage policies); and

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

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

    b. Resolving claim appeals and other internal grievances;

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

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

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 authorization from you. If the Plan receives a valid authorization, the Plan will disclose PHI to the person 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.

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 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:

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

- Ensure that any agents (such as union business agents or the Trustees' staffs), 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 such PHI;

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

- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the person who is the subject of the information;

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

- Make PHI available to a person who is the subject of the information according to the Privacy Regulations' requirements;

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

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

- 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; and

- If feasible, return or destroy all PHI received from the Plan 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).

Trustee Access to PHI for Plan Administration Functions

As required or permitted under the Privacy Regulations, the Plan will give access to PHI only to the following persons:

- **The Board of Trustees**. 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.

- **The Trustees' agents.** The Plan will release PHI to the Trustees' agents, such as Union Business Agents, and the Trustees' staffs, only to the extent reasonable to assist the Trustees in fulfilling their duties consistent with the above uses and disclosures of PHI.

The access for the above purposes will be limited, to the extent practicable, to a limited data set, or, if needed, to the minimum necessary to accomplish the intended purpose.

Noncompliance Issues

If the persons 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.

Plan's Privacy Official and Contact Person

As required by the Privacy Regulations, the Plan has named a Privacy Official 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

The federal Department of Health and Human Services adopted regulations governing the Plan's obligation to maintain the security of health information. The regulations arose from the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). These regulations work in conjunction with the Medical Data Privacy Regulations ("Privacy Regulations"), which provisions are found on pages 170-173 of the Summary Plan Description. While the Plan has always taken care to secure 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 protected health information. The information below outlines the additional steps the Plan has taken to secure health information in compliance with the HIPAA Security Regulations.

Policies to Protect PHI in Electronic Form

The Plan has implemented administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of protected health information (PHI) in electronic form (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these regulations) that they create, receive, maintain or transmit on behalf of the Plan. The Trustees will report to the Plan any security incident of which they become aware.

Business Associates

The Plan will enter into agreements with other entities known as "Business Associates" to 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 electronic PHI be maintained.

Access to PHI in Electronic Form for Plan Administrative Functions

As indicated in the section of the Summary Plan Description covering the Privacy Regulations, the Plan will give access to PHI to the Board of Trustees and agents of the Trustees such as Union and Employer Association staff. Any such disclosures of protected health information in electronic form to the above noted personnel 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, including disciplinary sanctions as appropriate.

If You Have Any Questions

The Plan is responsible for maintaining the security of PHI in electronic form. The Plan has appointed a Security Officer for purposes of Security Regulations compliance. An Eligible Individual may contact the security office through the Plan Administrator with any questions regarding the security of your PHI in electronic form.

HIPAA Special Enrollment Events

Notwithstanding any other provision of the Plan to the contrary, effective April 1, 2009, an Eligible Individual or his or her Dependent is entitled to special enrollment rights under Plan as required by HIPAA under either of the following circumstances:

- The Eligible Individual's or his or her Dependent's coverage under a Medicaid plan or under a state children's health insurance program is terminated as a result of loss of eligibility for such coverage and the Eligible Individual requests coverage under the Plan not later than sixty (60) days after the date of termination of such coverage.
- The Eligible Individual 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 Eligible Individual requests coverage under the Plan not later than sixty (60) days after the date the Eligible Individual or Dependent is determined to be eligible for such assistance.

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

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

- Sixty (60) days after the announced end of the COVID-19 National Emergency (which is ongoing and is sometimes referred to as the "Outbreak Period"); or
- One (1) year from the date the Eligible Individual was first eligible for relief from a HIPAA special enrollment period. The earliest date that a qualified beneficiary was first eligible for relief from a deadline related to a HIPAA special enrollment of the Fund Office of a COBRA Continuation Coverage qualifying event was either:
    - March 1, 2020 for HIPAA special enrollment events occurring on or before March 1, 2020, including periods by which notification of the special enrollment event was required to be completed that began before March 1, 2020. To be in this window, the last day of the applicable deadline must have been on or after March 1, 2020; or
    - Upon the occurrence of a HIPAA special enrollment event occurring after March 1, 2020, but before March 1, 2021.

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

You or your Dependent's obligation to notify the Plan of a HIPAA special enrollment event is extended to sixty (60) days after the end of the Tolling Period, subject to the Proration Rule. Remember that under the Proration Rule, if a HIPAA special enrollment event occurred prior to March 1, 2020, the extension periods are shortened by the number of days between the event and March 1, 2020.