St. Paul Electrical Workers' Health Plan

Summary Plan Description
Effective January 1, 2024

ST. PAUL ELECTRICAL WORKERS' HEALTH PLAN
SUMMARY PLAN DESCRIPTION

January 1, 2024

St. Paul Electrical Workers' Health Plan

Plan Administrator and Fund Office
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Introduction

As a Participant in the St. Paul Electrical Workers' Health Plan, You may be eligible for the following benefits:

Main Benefits

Medical Benefits

- Medical Benefits, including prescription drug benefits
- Dental Care Benefits
- Vision Care Service Plan

Other Non-Medical Benefits

- Disability Benefits
- Hearing Aid Benefits
- Medical Eligibility Bank Program
- Supplemental Unemployment/Medical Expenses (SUB/ME) Benefits
- Retiree Supplemental Medicare Coverage
- Jury Duty Benefits
- Life Insurance

Ancillary Benefits

- Employee Assistance Plan through TEAM
- Chronic Back Pain Program through TRIA Neck & Back Advantage Program
- Health Strategies EPIC Hearing, a discount program for hearing devices

This Summary Plan Description (SPD) booklet is designed to help You understand the benefits available to You. We urge You to read the booklet and share it with Your family. In addition, we recommend that You keep this booklet with Your important papers so You can refer to it when needed.

About This Booklet

In this booklet, we have tried to describe Your benefits in everyday language and organize it in a way that will be useful to You. This booklet includes:

- A listing of important contact information (page 1);
- A listing of the Benefit Program provided by the Plan (page 2);
- Information about when You and/or Your Dependents may participate in the Plan (page 3-4);
- An explanation of Your coverage under each benefit program (pages 7-Medical Eligibility Bank; 9-SUB/ME Plan; 17-Medical; 55-Dental Care; 61-Vision Care; 63-Hearing Aid; 63-Supplemental Retiree Medical Coverage; 68-Disability; 73-Life Insurance; 74-Jury Duty);
- Information about how to file claims and appeals (pages 47-Medical Claims; 50-Medical Appeals; 76-Other Claims);
- Plan administrative information (page 86); and
- A glossary of important definitions (page 92).

This booklet describes the benefits in effect as of January 1, 2024 or later. This edition replaces and supersedes any previous Summary Plan Description. The Trustees reserve the right and have the authority to amend, modify, or eliminate benefits, or to terminate the Plan at any time. Oral representations or interpretations are not permitted. In addition, the Trustees, or such other persons as delegated by the Trustees, have the discretion to interpret and construe the rules of the Plan. The Trustees' or their agents' exercise of discretionary authority is binding and will not be overturned or set aside by any court of law unless found to be arbitrary and capricious.

ANY MEDICAL TREATMENT CONSIDERED INVESTIGATIONAL OR EXPERIMENTAL OR IS NOT CONSIDERED TO BE AN ACCEPTABLE PRACTICE BY THE AMERICAN MEDICAL ASSOCIATION IS NOT COVERED BY THIS PLAN, UNLESS REQUIRED BY LAW.

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Important Contacts

If You need to:	Contact:	At:
Check eligibility	Fund Office	651-776-4239, Option 4 or 888-439-4239 www.speiasc.org
Find a Network Provider	UnitedHealthcare in the UnitedHealthcare Choice Plus Network	www.umr.com, or call the customer care center at 1-800-535-6373
To find a Network Provider; In-patient	UnitedHealthcare in the UnitedHealthcare Choice Plus Network	www.umr.com, or call the customer care center at 1-800-535-6373
Ask a question about medical benefits or dental care benefits	Wilson-McShane Corporation	952-851-5949
Ask a question about a medical claim or dental care claims	Wilson-McShane Corporation	952-851-5949
To find a participating pharmacy	CVS Caremark	www.caremark.com, or phone CVS Caremark toll free at 1-866-818-6911
To find a participating dentist or ask a question about dental care benefits	Wilson-McShane Corporation	952-851-5949 or 800-347-0401 or www.deltadentalmn.org
Ask a question about non-medical benefits (disability, ME, SUB, etc.)	Fund Office	952-851-5949
Change addresses	Fund Office	952-851-5949
Add/delete a Dependent	Fund Office	952-851-5949
Ask a question about life insurance	Fund Office	952-851-5949
Behavior Health Assessment, Short Term Counseling and Referrals	TEAM – Employee Assistance Program	651-642-0182 800-634-7710 TTY 800-627-3529 www.team-mn.com
Ask a question about chronic spine pain program	TRIA Neck & Back Advantage Program	651-735-2225, and say You are in the St. Paul Electrical Workers Health Plan
Ask a question about vision benefits or locate a VSP Network Provider	Vision Service Plan	1-800-877-7195 www.vsp.com
Health and Fitness Reward$	Gym Rewards Program	www.umr.com
Ask questions about hearing care benefits	Epic Hearing	1-877-606-3742, hearing impaired call 711 National Relay Service www.epichearing.com
Thorough Wellness Care Exam	Health Strategies	651-429-9891
Weight Loss Assistance	Real Appeal	www.enroll.realappeal.com
Access support from a health coach to bring in resources as needed to provide a continuum of care	Care Management Program	UMR MN 1-800-535-6373
Ask questions regarding your pregnancy	Maternity Management Program	UMR 1-800-535-6373
Get support to Quit Smoking	Quitting Tobacco Support Program	UMR 1-800-535-6373

Participation in the Plan: Eligibility, Enrollment and Coverage

General Description of Participants and Available Benefit Programs

You or Your Dependents who satisfy the eligibility requirements and enrollment requirements may participate in the following benefit programs:

Type of Employee or Dependent	Benefit Programs
Regular Employees	Medical Benefits Dental Care Benefits Hearing Aid Benefits Vision Care Service Plan Disability Benefits Medical Eligibility Bank* SUB/ME* Jury Duty Life Insurance TEAM Employee Assistance Program TRIA Neck & Back Advantage Program EPIC Hearing Health StrategiesHealth and Fitness Rewards (Gym Reimbursement) Real Appeal (Weight Loss Assistance) Retiree Supplemental Medicare coverage **
Regular Employee's Dependent (including Spouse)	Medical Benefits Dental Care Benefits Hearing Aid Benefits Vision Care Service Plan Medical Eligibility Bank* SUB/ME* TEAM Employee Assistance Program TRIA Neck & Back Advantage ProgramEPIC Hearing Health Strategies (spouse only) Health and Fitness Rewards (Gym Reimbursement) Real Appeal (Weight Loss Assistance) Retiree Supplemental Medicare Coverage**

* Excludes LEA agreement employees and their Dependents.

** For a Retiree and Spouse who are age 65 or older.

Type of Employee or Dependent	Benefit Programs
Non-Bargaining Unit Employee	Medical Benefits Dental Care Benefits Hearing Aid Benefits Vision Care Service Plan Disability Benefits (but not free extended medical coverage) Life Insurance Retiree Supplemental Medical Coverage** TEAM Employee Assistance Program Nurse Advice Line Nurtur Wellness/Disease Management TRIA Neck & Back Advantage ProgramEPIC Hearing Health and Fitness Rewards (Gym Reimbursement) Real Appeal (Weight Loss Assistance) Health Strategies
Non-Bargaining Unit Employee's Dependent (including Spouse)	Medical Benefits Dental Care Benefits Hearing Aid Benefits Vision Care Service Plan Retiree Supplemental Medical Coverage** TEAM Employee Assistance Program TRIA Neck & Back Advantage ProgramEPIC Hearing Health and Fitness Rewards (Gym Reimbursement) Real Appeal (Weight Loss Assistance) Health Strategies

Eligibility

Your Initial Eligibility and Initial Date of Coverage

Generally, You are eligible for benefits if You are:

- A member of IBEW Local Union No. 110 (the Union) or employed through the St. Paul Electrical Joint Apprenticeship Training Committee; and
- Your employer is obligated by an agreement between the Union and the St. Paul Chapter of the National Electrical Contractors Association (NECA).

Or

- You work for a Related Organization.

If You are a:

- Regular Employee. You become eligible on the first day of the month following receipt of employer contributions on Your behalf for at least three hundred (300) hours for work in Covered Employment.
    - If You are a Regular Employee and are employed in Covered Employment, You may self-pay the premium for coverage in the Plan until the three hundred (300)-hour eligibility requirement is satisfied. Coverage will start on the first of the month following the date of hire or the date of enrollment as determined by the Fund Office, provided the premium is paid.
    - If You are a Regular Employee who has three hundred (300) hours of contributions made to the Plan but are not working in Covered Employment on the first of the month following receipt of the three hundred (300) hours of contributions, You may elect to start coverage on the first of the month

following receipt of the three hundred (300) hours of contributions through self-payment or by using Your Medical Eligibility Bank.

- If You are a Regular Employee who had satisfied the three hundred (300)hours work requirement and ceased working but continued coverage as allowed by COBRA or the Plan provisions, when You return to work You may self-pay the premium for coverage in the Plan's Medical Benefits until the three hundred (300) hours eligibility requirement is satisfied, even if a COBRA period technically lapses. Coverage will start for these purposes on the first of the month following the date You return to work, provided the premium is paid.
- LEA employees are eligible to participate in the Plan as of the date specified in the LEA Agreement entered into between their employer and the Union. Generally, this is the first day of the month following the date of hire.
- If You are an owner-operator, You must remit contributions for at least three hundred (300) hours during any six (6)-month period to retain eligibility.

- Non-Bargaining Unit Employee. If You are employed by an Employer approved by the Trustees, You become eligible on the first day of the month for which Employer contributions in the amount determined by the Trustees are received.

Your effective date of coverage is the first day of the month as stated above. In order to include Dependents in Your coverage, You must provide a completed application form with supporting legal documents evidencing Dependent status as required by the Trustees, i.e., birth certificates or marriage license.

The Eligibility of Your Dependent

In general, Your Dependents include Your Spouse and Your dependent Children.

Your Dependent(s) become eligible for Plan benefits on the date You become eligible or, if later, on the date the person satisfies the definitions of Dependent. You must notify the Fund Office of any Dependents (current or new) and provide any requested materials before the Plan will pay benefits for Your Dependents.

In general, Your Dependents include Your Spouse and Your dependent Children. For detailed definitions of Child, Dependent, and Spouse, see page 93, respectively.

Enrollment

Initial and Continuing Enrollment

A Regular Employee will enroll in the Plan when he or she has satisfied the above noted Eligibility requirements and completes all necessary application forms for coverage as provided by the Fund Office. Coverage will start on the first of the month following the date of hire or the date of enrollment is completed as determined by the Fund Office.

To enroll Dependents, in all cases, You must complete and return to the Fund Office an enrollment application with the required supporting documentation, such as a marriage license and/or birth certificate. You must list all Your Dependents on the application. If You do not submit a properly completed application, benefit payments for Your Dependents are delayed until the Fund Office has a completed application for Your Dependents.

Adding a Dependent

To add a Spouse or a Child, You must contact the Fund Office for an enrollment application. Return the completed application along with any required supporting documentation to the Fund Office.

Coverage is effective on the date the person becomes a Dependent, as long as the completed application is received by the Fund Office within sixty (60) days of the person becoming a Dependent.

After sixty (60) days, the Spouse or Child will be covered beginning on the first of the month following receipt of the application.

Enrollment to Reinstate Coverage

If Your coverage is terminated and You return to work and become eligible again, You will need to complete a reinstatement application and return it to the Fund Office. Call the Fund Office for an application. (See page 15 on Reinstating Coverage.)

Special Enrollment for Loss of Other Coverage

If You are declining enrollment for Yourself or Your Dependents (including Your Spouse) because of other health insurance or group health plan coverage, You may be able to enroll Yourself and Your Dependents in this Plan if eligibility is lost for that other coverage (or if the employer stops contributing towards the other coverage). However, You must request enrollment within thirty (30) days after You or Your Dependents' other coverage ends (or the employer stops contributing toward the other coverage).

For special enrollments due to loss of other coverage, You or Your Dependent must otherwise be eligible for Plan coverage; and have been covered under another group health plan or other health insurance, including Medicaid or state Children's Health Insurance Program (CHIP), when coverage under this Plan was declined and enrollment must have been declined due to this other coverage.

If the other health coverage was COBRA continuation coverage in another plan, a special enrollment is only available after the COBRA continuation coverage has been exhausted. If the other coverage is not COBRA continuation coverage, a special enrollment is available if You or Your Dependents are no longer eligible for coverage or employer contributions for the other coverage.

Special enrollments are not available for loss of coverage due to failure to pay premiums, fraud, or misrepresentation. To be eligible for a special enrollment, You must notify the Fund Office within thirty (30) days of the loss of other coverage or the date of marriage, adoption, or placement for adoption (within sixty (60) days for special enrollment related to Medicaid or CHIP coverage).

To request special enrollment or obtain more information, contact the Fund Office.

Coverage

Initial Date of Coverage

Your initial date of coverage is the first of the month following satisfaction of an Eligibility Requirement, as stated on page 3 under "Your Initial Eligibility and Initial Date of Coverage." The effective Date of Coverage for Dependents is either the first of the month following certain criteria, or for certain New Dependents, it will be the date of birth, date of adoption or date of marriage.

When Coverage Ends

Coverage ends as specified below. Coverage may be continued in some instances through self-payment; by continuing coverage under federal laws known as COBRA, USERRA or by using funds in the Medical Plan Eligibility Bank or the SUB/ME. Certain retired employees may also continue coverage with some self-payment options.

For You

Coverage under the Plan will end on the earliest date listed below:

- The date the Plan ends;

- The date You enter active military service;
- At the end of the month in which You terminate active employment or are no longer working in Covered Employment (unless You can continue coverage under the Plan's Medical Eligibility Bank provisions);
- The last day of the month in the month in which You die;
- The end of the month for which insufficient contributions have been made on Your behalf;
- The end of the month before any month for which You do not pay the required monthly charge if sufficient contributions are not made on Your behalf;
- For Regular Employees who are owner-operators, at the end of any six (6)-month period where contributions have not been remitted for at least three hundred (300) hours;
- For Non-Bargaining Unit Employees, at the end of the month in which the Employer Related Organization is no longer in compliance with or employing at least one employee under the provisions of any agreement(s) approved by the Trustees;
- The end of the month before any month in which You do not make the required self-payment for coverage under the provisions of the Plan; or
- The date on which You perform an act, practice or omission that constitutes a fraud on the Plan or make an intentional misrepresentation of a material fact or abuse the provision of benefits under this plan. Such actions include but are not limited to submitting fraudulent misstatements or omissions about medical history or eligibility status; submitting fraudulent, altered, or duplicate billings for personal gain; allowing another party not eligible for coverage under the Plan to use coverage; and/or repeatedly request coverage for benefits that are not Medically Necessary or cumulatively exceed reasonable and customary expenditures for a medical issue.

For Your Dependent(s)

Your Dependent's coverage will end on the earliest date listed below:

- The date he or she becomes an Eligible Employee in the Plan, unless he or she is a dependent Child who elects to remain on his or her parent member's coverage until age twenty-six (26);
- The date he or she no longer satisfies the definition of a Dependent under the Plan;
- The date the Plan discontinues all Dependent coverage;
- Immediately when Your, the member's, coverage ends;
- The Dependent requests in writing to end coverage;
- The date of his or her death; or
- The date on which You or Your Dependent performs an act, practice or omission that constitutes a fraud on the Plan or make an intentional misrepresentation of a material fact or abuse the provision of benefits under this plan. Such actions include but are not limited to submitting fraudulent misstatements or omissions about medical history or eligibility status; submitting fraudulent, altered or duplicate billings for personal gain; allowing another party not eligible for coverage under the Plan to use coverage; and/or repeatedly request coverage for benefits that are not Medically Necessary or cumulatively exceed reasonable and customary expenditures for a medical issue.

Notification of Termination of Coverage

If You or Your Dependent's coverage in the Plan has been terminated for any reason, You or Your Dependent will be notified in writing of the termination by the Fund Office. This notification will be mailed to You or Your Dependent at the address provided to the Trustees. If You or Your Dependent fails to receive this written notification, it will not affect the termination of Your coverage or Your Dependent's coverage.

Do not miss important information from the Plan. Keep Your address information current with the Fund Office.

Rescission or Termination of Coverage for Fraud or Abuse

The Plan prohibits You from performing an act, practice, or omission that constitutes fraud or from making an intentional misrepresentation of material fact, that in any respect relates to Your enrollment in the Plan, Your eligibility for coverage by the Plan, the coverage You seek under the Plan or to the treatment for which You seek coverage under the Plan. If You engage in such fraud or make such a misrepresentation, the Plan may rescind Your coverage retroactive to the date of the fraud or misrepresentation. The Plan will provide at least thirty (30) days advance written notice to each Participant who would be affected before coverage is rescinded pursuant to this provision.

Continuation of Coverage – Medical Benefits

If Your coverage ends, You or Your Dependents may continue coverage in the medical benefits in the Plan (Medical, Dental Care and Vision Care) as allowed by laws known as COBRA or USERRA.

Regular Employees (or a Dependent of a Regular Employee) may have account balances available to them through the Medical Plan Eligibility Bank and/or the SUB/ME program. If You continue coverage under COBRA or USERRA, You may pay for such coverage using any one or more of the following methods: (1) Funds available through the SUB/ME Program; or (2) Self-payment.

If You suffer a Temporary Total Disability or a Total Permanent Disability, You may continue coverage for free for a period of time and subject to certain limitations described in detail starting at page 68-71.

If Your continuation period under COBRA or USERRA, or self-payment expires, You may be able to reinstate coverage as described on page 14.

Continuing Coverage Through Medical Plan Eligibility Bank (Regular Employees Only)

The Medical Plan Eligibility Bank (Eligibility Bank or Bank) allows Regular Employees who experience a severance of employment or do not have sufficient hours to continue coverage for medical benefits (Medical, Dental Care, and Vision Care) to use their Bank to help pay for coverage. If the Bank dollars are used to continue coverage for medical benefits after a severance of employment or reduction in hours, there is no COBRA event until the Bank dollars are exhausted.

Eligibility

Regular Employees employed under Agreements that provide for the Medical Plan Eligibility Bank will have Employer contributions made for this purpose on their behalf. Each eligible employee will have a separate account. If You work more than the required hours needed to pay for a month of benefits, your excess hourly contributions will be added to YourBank.

Benefits

The account may be used to pay monthly health plan premium payments for medical benefits (Medical, Dental Care, and Vision Care) as follows:

- For You, for premiums for coverage in either this Health Plan, continuation coverage in this Health Plan, or as reimbursement for substantiated premium costs to obtain health coverage in another employer-sponsored health plan;

- For Retirees, for premiums for coverage as a Retiree in this Health Plan, the Supplemental Medicare Coverage Plan, Medicare Part B or as reimbursement for substantiated premium costs to obtain health coverage in another employer-sponsored health plan; or

- For surviving Dependents for premiums for coverage in this Health Plan, the Supplemental Medicare Coverage Plan, Medicare Part B or as reimbursement for substantiated premium costs to obtain health coverage in another employer-sponsored health plan.

All requests for reimbursement of premiums paid to another employer-sponsored health plan must be substantiated and must include an attestation that You (or Your surviving Dependents) are covered by such plan. All such claims must be submitted within twelve (12) months of the date the expense was incurred. The amount reimbursed may not exceed the Eligibility Bank account balance. The Trustees determine, in their discretion, if requested amounts will be reimbursed.

Forfeiture of Your Eligibility Bank Account

The contributions in Your Eligibility Bank account will be forfeited back to the Trust, if any of the following events occurs:

- The Health Plan is discontinued.
- If you are separated from Your Employer (other than for Early Retirement or Normal Retirement) and You have lost coverage under the Plan, your account is forfeited on the thirty-sixth (36^{th}) month following the loss of coverage in the Plan.
- You are found to be in violation of the collective bargaining agreement.
- You die without a surviving Dependent.
- You die and Your surviving Dependent declines coverage or dies.
- You do not elect to self-pay for coverage or lose coverage in this Plan or another employer-sponsored health plan, Your account will be forfeited twenty-four (24) months from the date You lost coverage.
- You enter into active military service, but only if You return from active duty, are not disabled, and do not return to Covered Employment within ninety (90) days after returning from active duty. If You return from active duty, but are disabled and cannot return to Covered Employment within ninety (90) days, then Your account balance may be used to pay for medical benefits coverage in this Plan or another employer-sponsored health plan until the disability ends or the account balance is exhausted.
- If, on or after Early Retirement, You elect to opt out of the Plan, You have a one-time opt-out opportunity to return to the Plan. Once Your opt-out period is over, if You have a break in coverage with this Plan for twenty-four (24) months, Your account in the Bank will be forfeited. See the opt-out rules in the box on page 13.

Continuing Coverage Through SUB/ME Plan (Regular Employees Only) and SUB/ME Benefits

If You are a Participant in the SUB/ME Plan, You may use Your account balance in the SUB/ME Plan to pay for premiums for medical benefits (Medical, Dental Care, and Vision Care) in the Plan. Prior to using SUB/ME funds, You must have exhausted any funds available to You in the Eligibility Bank, which may trigger a COBRA qualifying event.

The SUB/ME Plan provides benefits, if You are eligible, to supplement State Unemployment Compensation benefits, workers' compensation payments and/or to help pay medical premiums, Deductibles and Co-insurance.

Eligibility in SUB/ME

You are eligible if the Collective Bargaining Agreement (CBA) requires contributions on Your behalf to the Supplemental Pension Plan and any one of the following applies to You:

- You are a Participant in the Health Plan;
- You are a Participant in the Health Plan and no longer working in Covered Employment; or
- You are retired.

The following groups are not eligible for the SUB/ME Plan:

- LEA agreement members and
- Retirees returning to Covered Employment.

Accumulating Your SUB/ME Account Balance

If You are eligible, an account is established for You. Your Employer contributes to the account on Your behalf.

Contributions into Your account can accumulate up to either of the following balance amounts:

Option (1): Six Thousand Dollars ($6,000) automatically; or,

Option (2): Twenty Thousand Dollars ($20,000) should You elect by completing an election form and submitting it to the Fund Office.

Electing Option (2): While Option (2) above is available for any Participant in the SUB/ME Plan, it is best considered if You do not regularly work enough hours during the year or regularly experience seasonal reductions in your hours of employment such that you may lose coverage and need to make self or COBRA payments to continue your coverage under the Plan.

Subject to Forfeiture: It is important to note that your SUB/ME Account is subject to the "*Forfeiture of Your SUB/ME Account*" provisions detailed below. The trustees recommend you keep those forfeiture provisions in mind in accumulating a balance above the $6,000 base maximum. If you do not regularly experience such breaks in your employment, exceeding the base $6,000 SUB/ME Account threshold may be unnecessary.

Discontinuing SUB/ME Account Accrual under Option (2): If You complete an election form to allow your SUB/ME to exceed the $6,000 threshold in Option (1) above, you can later elect to stop accruing contributions prior to reaching the $20,000 maximum allowed for in Option (2) above by completing an election change form with the Fund Office. However, you will not be able to transfer that accumulated balance to any other plan for which contributions are made on your behalf. Furthermore, as noted above,

your SUB/ME account remains subject to the "Forfeiture of Your SUB/ME Account" provisions detailed below.

Earnings, Gains and Losses: Your account value may exceed the above noted amounts under either Option (1) or (2) based on earnings (gains/losses) that the Trustees apply to all accounts from time to time.

Examples of Option (2) SUB/ME Account Operation:

- **Example No. 1:** John elects to have his SUB/ME accrue above the $6,000 amount. When his account accumulates to $14,000, he elects to stop accumulating any further contributions into his SUB/ME Account. He must complete an election form to stop the contributions from going to his SUB/ME Account. His balance will continue to accrue interest. He can use his balance for any permissible SUB/ME Account benefits. However, John is not permitted to transfer his balance to any other account or use the balance for any benefits that are ineligible for payment under the SUB/ME Account.

- **Example No. 2:** John elects to have his SUB/ME accrue above the $6,000 amount. When his account accumulates to $20,000, he will not be able to accumulate any further contributions in his SUB/ME Account. His balance will continue to accrue interest. He can use his balance for any permissible SUB/ME Account benefits. However, John is not permitted to transfer his balance to any other account or use the balance for any benefits that are ineligible for payment under the SUB/ME Account. If John's balance drops below $20,000, he may once again elect to receive contributions into his SUB/ME Account and allow them to accumulate up to the $20,000 maximum.

- **Example No. 3:** John has accumulated up to $20,000 in his SUB/ME Account and in fact upon reaching the maximum, has continued to earn interest such that as of January 31, 2025, he has accumulated a balance, with interest, of $22,500. John separated from employment with his employer on January 31, 2025, and loses coverage under the Plan and chooses not to access his SUB/ME Account to make self-payments to continue his coverage. If John does not return to coverage under the Plan by February 1, 2028, he will forfeit the entirety of his balance in his SUB/ME Account.

SUB/ME Benefits

You may use Your SUB/ME account to pay for the following benefits:

- You may receive Two Hundred Fifty Dollars ($250) a week (subject to tax withholding), if You are receiving (and have been receiving for three weeks) Workers' Compensation or if you are receiving disability benefits under Part A of the Plan and if You have at least One Thousand Two Hundred Dollars ($1,200) in Your account;
- You may receive Two Hundred Fifty Dollars ($250) a week (subject to tax withholding), if You are receiving (and have been receiving for three weeks) Unemployment Compensation for unemployment and if You have at least One Thousand Two Hundred Dollars ($1,200) in Your account;
- The account may be used to pay monthly medical premiums for You, Retirees (even with the Retirement Medical Funding Plan), or surviving Dependents;
- If You have not worked sufficient hours to make a full contribution to the Health Plan and You have received a bill from the Health Plan and have not responded within twenty-one (21) days of the invoice date from the Health Plan, You will pay for continued medical coverage from Your SUB/ME account, after Your Medical Eligibility Bank account is exhausted; or
- The SUB/ME Plan also reimburses the following tax-deductible medical expenses for You or Your Dependents;
    - Annual Deductibles under this Health Plan, the Supplemental Medicare Coverage Plan or under another employer-sponsored group health plan,

- Co-insurance (the amount You pay, after the Plan pays benefits) for medical expenses for Yourself or Your Dependent under this Health Plan, the Supplemental Medicare Coverage Plan or under another employer-sponsored group health plan, or
- Insurance premiums for You or a Dependent for this Health Plan, Supplemental Medicare Coverage Plan, Medicare Part B or under another employer-sponsored group health plan. All requests for reimbursement of premiums paid to another employer-sponsored health plan must be substantiated and must include an attestation that You (or Your surviving Dependents) are covered by such plan.

Filing a claim for reimbursement from the SUB/ME for the above noted expenses must be done on a form approved by the Trustees (available in the Fund Office) and include documentation that substantiates the expense actually incurred and its specific nature. All claims for medical expense reimbursement must be submitted within twelve (12) months of the date the expense was incurred. The amount reimbursed from a Participant's SUB/ME account shall not exceed the balance of the account on the date the claim for reimbursement was filed. The Trustees, in their discretion, shall determine whether a claimed expense will be reimbursed.

NOTE: Some benefits provided through the SUB/ME may be taxable.

Forfeiture of Your SUB/ME Account

The contributions in Your SUB/ME account will be forfeited back to the Trust, if any of the following events occurs:

- You are separated from Your Employer (other than for Early Retirement or Normal Retirement) and You have lost coverage under the Plan, Your account is forfeited on the thirty-sixth (36th) month following the loss of coverage in the Plan.
- You are found to be in violation of the Collective Bargaining Agreement.
- You die without a surviving Dependent.
- You die and Your surviving Dependent declines coverage or dies.
- You do not self-pay for coverage and lose coverage on the last day of the month for which coverage was paid, then Your SUB/ME account will be forfeited on the thirty-sixth (36th) month after You lose coverage.
- If, on or after Early Retirement, You elect to opt out of the Plan, You have a one-time opt out allowance. For example, if Your Spouse continues employment and covers You under his or her employer's benefits, then You can elect to opt out of this Plan until Your Spouse and You lose coverage under that plan. Once Your opt-out period is over, if You have a break in coverage with this Plan for thirty-six (36) months, Your account will be forfeited.
- You enter into active military service, but only if You return from active duty, are not disabled, and do not return to Covered Employment within ninety (90) days after returning from active duty. If You return from active duty, but are disabled and cannot return to Covered Employment within ninety (90) days, then Your account balance may be used to pay for coverage until the disability ends or the account balance is exhausted**.**

Continuing Coverage in Medical Benefits Through Self-Payments (Non-COBRA)

This section describes when You or Your Dependents lose coverage but may continue coverage through regular self-payments.

For Regular Employees

If You are a Regular Employee and You are granted a participating withdrawal from IBEW Local Union 110 or a disability pension from the National Electrical Benefit Fund (NEBF), but are not eligible for the

Disability Benefit, You may continue coverage by paying the monthly cost for coverage before the month for which coverage is elected. Coverage will end according to Plan provisions (as described on page 5). Coverage cannot be extended beyond the earlier of:

- The date You reach age 65;
- The effective date of Your Medicare eligibility if You have retired or are SSA disabled;
- The date the participating withdrawal ends;
- The date You violate the Collective Bargaining Agreement; or
- The date You are no longer receiving the NEBF disability pension.

For a Surviving Dependent Spouse

If You die, Your Dependent Spouse's coverage would normally end at Your death; however, Your Spouse may continue coverage to the first day of the month in which he or she reaches age 65 or becomes eligible for Medicare, or on the date Your Spouse remarries, if:

- You were a Regular Employee or a Non-Bargaining Unit Employee;
- You had at least sixty (60) consecutive months of coverage under the Plan; and
- Your Spouse pays the monthly cost of coverage on a timely basis. Your surviving Spouse may use any amounts in Your Eligibility Bank or Your SUB/ME to pay these premiums.

For Your Divorced Spouse

If You and Your Spouse divorce or legally separate and a court decree requires You (the Participant) to pay the COBRA premiums for Your Spouse, then Your Spouse may continue coverage at no additional cost under this Plan. However, this extended coverage ends when either You or Your Spouse dies, if Your Spouse becomes eligible for coverage elsewhere including Medicare, or You or Your Spouse remarries. If your divorced spouse still has COBRA coverage time remaining due to the divorce, they can maintain their COBRA coverage by paying the monthly COBRA premium through the end of their remaining COBRA coverage period.

In order to obtain this benefit, Your former Spouse must elect COBRA coverage within the time limits specified for a divorce. (See Exhibit A to this SPD.) In addition, You and Your former Spouse must provide to the Fund notice of Your divorce and the court order requiring payment of COBRA premiums as soon as practicable. DELAY IN PROVIDING THE COURT ORDER MAY RESULT IN DENIAL OF THIS BENEFIT.

For a Retiree

If You are a Regular, full-time Bargaining Unit Employee, or Non-Bargaining Unit Employee, You may continue coverage in this Plan when You retire if You:

- Were a Participant in the Plan at the time of Your retirement;

- Had a minimum of sixty (60) months of participation (as long as the months are consecutive or the period in covered employment after an interruption is greater than the interruption, if any) in the Plan immediately preceding Early Retirement; and
- Make payments to the Plan for coverage.

When You retire, You have these four options (or, for Non-Bargaining Employees, two options):

- **One-Time Opt-Out for Regular Employees**
- You may opt out of coverage under this Plan only once. When You return to this Plan, You must show that You (and any Dependents) were continuously covered under the other plan until You came back to this Plan. You will have to self-pay for coverage.

If You are eligible to receive a contribution allowance from the Retirement Medical Funding Plan for St. Paul Electrical Workers, You can use this allowance to offset Your self-payments.

1. If You are a Regular Employee, You may choose to opt out of the Plan's coverage, because You are covered under Your Spouse's employer's plan and Your Spouse will continue to work. Should You die, Your Spouse will also retain this ability to opt-out of the Plan and then later opt-back into the Plan to receive coverage. You, or Your surviving Spouse, may opt out of coverage under this Plan only once and must show continuous coverage under the other plan until returning to this Plan.

2. If You are a Regular Employee, You (and Your Spouse, if applicable) may choose to opt-out of coverage under the Plan to enroll in coverage under a MNSure Health Insurance Plan, WisCovered (Wisconsin) Health Insurance Plan or any other state-sponsored medical exchange health insurance coverage. Please note, that if You (and Your Spouse, if applicable) elect this option, You (or Your Spouse) **cannot** return to coverage under this Plan until such time as either You or Your Spouse reach age 65 (or otherwise become eligible for Medicare) and therefore become eligible for the MAPD Plan sponsored by this Plan.

   For example, if You and Your Spouse opt-out of Plan coverage under Option No. 2:

   - If You are age 60 and Your Spouse is 58 when You opt-out of coverage under this Plan, You can return to the Plan to enroll in MAPD coverage when You reach age 65 but Your Spouse would need to remain on MNSure, WisCovered or other similar exchange coverage until they also reach age 65 and therefore become eligible for the Plan's MAPD Plan.

   - The opposite is also true. If Your Spouse reaches age 65 before You do, Your Spouse may return to be covered under the Plan's MAPD Plan but You will have to maintain MNSure, WisCovered or other similar exchange coverage until You reach age 65 before returning to the Plan for MAPD coverage.

   To receive the MAPD Plan upon reaching age 65, You and Your spouse (if applicable) must have maintained continuous ongoing health insurance coverage without break from the time of your opt-out of coverage under this Plan until your return to enroll in the MAPD Plan.

3. You may choose to continue coverage in this Plan through self-payments, as long as You are not yet eligible for Medicare.

4. If You are eligible for Medicare, You may choose Supplemental Retiree Medicare Coverage as described on page 39. If You have covered Dependents who are not eligible for Medicare, You may continue to cover them in the active Plan while You are covered through Supplemental Retiree Medicare Coverage, an insured plan. You will have to self-pay for Your Dependents and Yourself. You may continue Dependent coverage until Your last Dependent either becomes eligible for Medicare or no longer meets the definition of Dependent under the Plan. In the event Your Dependent no longer meets the definition of a Dependent under the Plan, Your Dependent may be able to continue coverage under COBRA (see page 13). Once You or Your Dependent becomes eligible for Medicare, Medicare coverage will be considered primary for that individual, as described on page 42.

Deduct Premiums from Your Pension: If You are receiving a pension check from the St. Paul Electrical Construction Pension Plan and You are self-paying to continue coverage in this Health Plan, You may elect to have Your premium payments deducted from Your pension check and remitted to this Plan.

For a Dependent of a Deceased Retiree

Coverage of a Dependent may continue even if the coverage would normally terminate because You retire, if You:

- Are eligible for a pension from the St. Paul Electrical Construction Pension Fund, and
- Die after retirement.

Your Dependent will have to pay the monthly cost of coverage. Your Dependent may use any amounts in Your Eligibility Bank or Your SUB/ME account to pay for these premiums.

Continuing Coverage While Disabled

In addition to Your COBRA and USERRA rights, if You suffer a Temporary Total Disability or Permanent Total Disability, You may continue medical benefits coverage for free for a period of time. Go to pages 68-71.

Continuing Coverage Through COBRA Continuation Coverage

COBRA Continuation Coverage is a temporary extension of group health coverage under certain circumstances when coverage would otherwise end. If You experience a COBRA event, the Plan allows You to continue the medical benefits (Medical, Dental Care, and Vision Care) in the Plan.

This section provides a general explanation of COBRA Continuation Coverage, when it may be available to You and Your family, and what You need to do to protect Your right to receive it.

COBRA Continuation Coverage becomes available to You when You would otherwise lose Your group health coverage under the Plan. It also becomes available to Your Spouse and Children (Your Dependents) who are covered under the Plan when they would otherwise lose their coverage.

You or Your covered Dependents may continue coverage under the group health benefits in this Plan if current coverage ends because of any of the qualifying events listed on the following page. (Please note that there may be other coverage options available to You and Your family including being able to purchase coverage through the Health Insurance Marketplace, instead of continuing Your coverage under this Plan.) You or Your Dependent must be covered under the Plan before the qualifying event in order to continue coverage. In all cases, continuation ends if the Plan ends or required premiums are not paid when due.

The following table generally describes continuation coverage under this Plan. Also, refer to *Initial COBRA Notice* attached to this Plan as Exhibit A for more information.

Qualifying Event	**Who May Continue**	**Maximum Continuation Period**
Employment ends, certain leaves of absence, layoff, or reduction in hours (except gross misconduct dismissal)**	Employees and Dependents	Earlier of: 1. Enrollment date in other group coverage, or 2. Eighteen (18) months
Divorce	Former Spouse and any dependent Children who lose coverage	Earlier of: 1. Thirty-six (36) months from the date of divorce 2. Enrollment date in other group coverage, or

Qualifying Event	Who May Continue	Maximum Continuation Period
	Note: A Divorced Spouse may be able to continue coverage as allowed on page 12 of this Plan.	3. Date coverage would otherwise end
Death of Employee	Surviving Spouse and Dependent Children	Earlier of: 1. Thirty-six (36) months from the date of death 2. Enrollment date in other group coverage, or 3. Date coverage would otherwise end
Dependent Child loses eligibility	Dependent Child	Earlier of: 1. Thirty-six (36) months from the date of losing eligibility 2. Enrollment date in other group coverage, or 3. Date coverage would otherwise end
Total Disability	Employee and Dependents	Earliest of: 1. Eighteen (18) months, or 2. Twenty-nine (29) months after the qualifying event, or 3. Date Total Disability ends, or 4. Date of enrollment in Medicare, or 5. Date coverage would otherwise end

** For Regular Employees, if You experience a severance of employment, leave of absence or layoff, if You have Eligibility Bank dollars, You do not have a COBRA event until the first of the month following the month in which Your Eligibility Bank is exhausted.

Continuation of Coverage Due to Military Service (USERRA)

If You leave work for military service and the military service is for thirty (30) or fewer days, You and Your Dependents may continue health plan coverage at one hundred percent (100%) of premium cost. If military service lasts more than thirty (30) days, You and/or Your Dependents may continue coverage for a period of up to twenty-four (24) months at one hundred two percent (102%) of the coverage ("applicable premium") cost.

Coordination of USERRA and COBRA

When You or Your Dependent loses coverage under the Plan and You or Your Dependent is eligible to continue medical benefits coverage through USERRA or COBRA, then You or Your Dependent may elect the type of continuation coverage to use. If You elect USERRA, Your coverage level does not change and no optional levels of coverage are offered. If instead You elect COBRA coverage, then two options are offered – Full (medical, dental care and vision care, no disability) or medical only. If You are eligible for either USERRA or COBRA coverage, then Your election of one type of coverage will mean that You waive the others. For example, if You elect the USERRA option, Your election waives Your right to COBRA coverage.

Coverage During a Family and Medical Leave of Absence

Not all Employers are covered by FMLA, and the benefits of this law do not extend to employees of such Employers. If You are uncertain as to whether FMLA applies to You, ask Your Employer or the Plan Administrator.

If You and Your Spouse both work for the same Employer, You and Your Spouse are eligible for a combined total of twelve (12) weeks of leave during a twelve (12)-month period.

If You cease to work due to an Employer-approved family medical leave of absence in accordance with the requirements of the Federal Family and Medical Leave Act of 1993 (or in accordance with any state or local law which provides a more generous medical or family leave and requires continuation of coverage during leave), coverage will be continued under the same terms and conditions which would have been provided had You continued to work.

Reinstating Coverage

If Your eligibility for coverage under the Plan ends, You will need to meet the Plan's initial eligibility requirements to reinstate Your eligibility for coverage (see page 5), however, there are certain exceptions as noted below and also as described on page 5.

If You are a Regular Employee and You return to work in either the Home Area or a Reciprocal Area, You may pay the full premium to obtain coverage effective the first day of the month following Your return to work, until You have established the three hundred (300) hours of employer contributions. You must complete a new application for any Dependents You want to cover under the Plan.

If Your coverage ends after You entered military service under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), and You return to work in the jurisdiction covered by the Plan, You will be immediately eligible for coverage under the Plan on the first day of such reemployment.

Keep the Fund Office Informed of Changes and Keep Copies of Notices

To protect You and Your family's rights, You should keep the Fund Office informed of any changes in status or in Your address and the addresses of Dependents. You also should keep a copy, for Your records, of any notices You send to the Fund Office. Inform the **Fund Office** of:

- Change of Address
- Marriage
- Divorce
- Birth of Child
- Adoption of Child
- Death of Member
- Death of Dependent
- Receipt of SSA Total Disability Determination

NOTIFICATION MUST BE MADE TO THE **FUND OFFICE**. Changes of information that You make to the Union office are **NOT** made or transmitted to the Fund Office.

Medical Benefits

The Medical Plan

The Medical Plan provides coverage for certain medical expenses for Eligible Employees and their Dependents who enroll in the Plan. The Plan pays the **Allowed Amount** of **Covered Charges** after Participant pays applicable **Co-pays**, **Deductibles** and **Co-insurance**.

The actual Medical Benefits provided under the Plan depend on whether the health care Provider is **In-Network** or **Out-of-Network**. **In-Network Providers** are Providers who maintain a contract with UnitedHealthcare and serve as a participating Provider in the network established by the Plan through its contracts with UnitedHealthcare. If You do not use Doctors and healthcare facilities that are In-Network, You will be covered by lesser benefits.

UnitedHealthcare maintains the Provider directory of the In-Network Providers at their website, www.umr.com. The list of In-Network Providers may change as Providers initiate or terminate their network contracts. **DETERMINE WHETHER YOUR PROVIDER IS IN-NETWORK OR OUT-OF-NETWORK PRIOR TO RECEIVING ANY CARE TO AVOID PAYING ADDED COSTS RELATED TO USING AN OUT-OF-NETWORK PROVIDER.**

Out-of-Network Providers are NOT obligated to accept the **Allowed Amount** as payment in full; they may charge more. Plus, the Plan may impose a different Allowed Amount for an Out-of-Network Provider that is less than the Allowed Amount for the same service by an In-Network Provider. For example, the Plan will only pay out for any Out-of-Network claims the lesser of the amount the non-participating Provider charges or 175% of the Medicare Like Rates (MLR) for the particular service or claim (unless subject to the No Surprises Act). This means that You may have substantial Out-of-Pocket expense when You use an Out-of-Network Provider **Claims and Benefits.**

Certain Services, procedures and medical devices require **Preauthorization**, as listed in the **Schedule of Medical Benefits** and as subsequently modified. Pre-authorization is a process that involves a benefits review and determination of Medical Necessity before Services, procedures or devices are provided and costs are incurred. In-Network Providers are obligated through their contracts with UnitedHealthcare to obtain Preauthorization for You. The Preauthorization requirements are modified by UnitedHealthcare from time to time, so contact Wilson-McShane Corporation to determine when You need to obtain Preauthorization or provide Notification.

Provisions governing submission of claims to the Medical Plan are described starting at page 47. **All claims must be submitted within twelve (12) months of the date service was rendered. If the claim is not submitted on a timely basis, it will be denied.**

- Please note that there is a separate Dental Care Plan, described at page 57 and a separate Vision Care Service Plan, described at pages 61-62.

SCHEDULE OF MEDICAL BENEFITS

Benefit	In-Network	Out-Of-Network Coverage
Annual Deductible (Medical) Individual Family (2 or more family member)	 $750 per Calendar Year $1,500 per Calendar Year	 $750 per Calendar Year $1,500 per Calendar Year
Annual Medical Out-of-Pocket Maximum (Medical OOP) Individual Family (2 or more family members)	 $1,500 per Calendar Year $3,000 per Calendar Year **NOTE:** In-Network Medical Co-pays, Deductibles and Co-insurance count toward In-Network Medical OOP	 $3,000 per Calendar Year $6,000 per Calendar Year **NOTE:** Out-of-Network Medical Co-pays, Deductibles and Co-insurance count toward Out-of-Network Medical OOP
Annual Prescription Out-of-Pocket Maximum (Prescription OOP) Individual Family (2 or more family members)	 $5,650 $11,300 **NOTE:** Prescription Co-pays and Coinsurance count toward Prescription OOP only	 No coverage No coverage
I.D. Card Use	Must be shown at time of service	Must be shown at time of service
E-Visit / Telemedicine	Plan pays 100% (No Co-pay) (Teladoc only)	60% after Deductible

NOTES ON COVERAGE:

- The Plan pays the Allowed Amount of Covered Charges after Participant pays applicable Co-pays, Deductibles and Co-insurance.
- Out-of-Network Providers may charge more than the Allowed Amount and the Allowed Amount for an Out-of-Network Provider may be different from the same service by an In-Network Provider. Out-of-Network Providers may charge more than the Allowed Amount and the Allowed Amount for an Out-of-Network Provider may be different from the same service by an In-Network Provider. The Plan will only pay for any Out-of-Network claims the lesser of the amount the Out-of-Network Provider charges or 180% of the Medicare Like Rates (MLR) for the claim.
- Certain Services, procedures and devices require Prior Authorization and Approval including In-patient Hospital, Home Health Care, Acute Care Admissions, Residential Behavioral Health Facility, Skilled Nursing Facility, Skilled Nursing Care, Hospice Care, certain surgeries and procedures, and certain Durable Medical Equipment.
- Deductible payments are tracked In-network and Out-of-Network only for purposes of application to the appropriate Out-of-Pocket Maximum. Any Deductible payment, whether it is In-Network or Out-of-Network, is counted for satisfying the applicable individual and family Deductible limits.
- There may be circumstances where You require medical or surgical care, and You do not have the opportunity to determine if the Provider is In-Network or Out-of-Network. Generally, if you use an

Out-of-Network Provider, You will be responsible for more of the charges than if an In-Network Provider was used. However, in circumstances where You needed care, and you were not able to choose the Provider who rendered the care, the Plan may pay an amount such that You are paying less than Out-of-Network charges and possibly down to In-Network charges, as established by the Trustees in their discretion. This provision relates only to lab and diagnostic testing, anesthesiologist and ambulance services.

- ***No Surprises Act*** **-** Under the No Surprises Act, you will not be subject to surprise or balance billing when you receive the following types of care:
    - Emergency care; or
    - Treatment by an out-of-network provider at an in-network hospital or ambulatory surgical center.

Balance Billing (sometimes called "surprise billing")

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in the Plan's United Healthcare network.

"Out-of-network" describes providers and facilities that haven't signed a provider agreement with United Health Care. Out-of-network providers may be permitted to bill you for the difference between what the Plan agreed to pay, and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is the Plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is the Plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network and the Plan would strongly encourage you to seek care from providers in the United Healthcare Network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). The Plan will pay out-of-network providers and facilities directly.

- The Plan will:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what the Plan would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit under the Plan.

Preventive Health Care

Covered	In-Network	Out-of-Network Coverage
Preventive Health Care	100% (No Deductible)	Deductible, then 60%
In-Network Preventive Health Care includes items or Services described in federal regulations, including certain immunizations, wellness screening, prenatal Services and contraception. The Plan covers the Preventive Health Care Services and items required by federal statute and regulation.		

NOTES ON COVERAGE:

- Routine Hearing Exams: Coverage is limited to one (1) exam per Participant per Calendar Year, unless prescribed more often by a Physician.
- Colonoscopies: Coverage is provided as Medically Necessary. This Plan does cover virtual colonoscopies.
- Prenatal Preventive Health Office Visits include prenatal office visits that deal with non-routine diagnoses in the pregnancy. Two ultrasounds are covered one hundred percent (100%) as preventive care per pregnancy. Additional ultrasounds or imaging are subject to plan Co-pays and Deductibles.
- Current In-Network Preventive Care that is covered one hundred percent (100%) under USPSTF Guidelines includes:

Preventive Services for Adults, who meet certain criteria, as follows:

Abdominal Aortic Aneurysm screening for men who have smoked.	Depression screening	Obesity screening and counseling
Alcohol misuse screening and counseling	Type 2 diabetes screening and counseling	Weight Loss Programs to treat obesity
Blood Pressure screening	Diet counseling for adults with higher risk for chronic disease	Sexually Transmitted Infection prevention counseling
Cholesterol screening	HIV screening; certain Immunizations	Tobacco Use screening and cessation interventions
Colorectal screening for adults over 50	Lung cancer screening for certain adults age 55 – 80	Syphilis screening

Preventive Services for Women, who meet certain criteria, as follows:

Anemia screening for pregnant women	Chlamydia Infection screening	Contraception (FDA approved contraceptive methods, sterilization procedures and patient education and counseling, not including abortifacient drugs)
Bacteriuria urinary tract or other infection screening for pregnant women	Folic Acid supplements	Domestic and interpersonal violence screening and counseling

Breastfeeding support and counseling	Gonorrhea screening	Gestational diabetes screening and counseling
BRCA genetic test counseling	Hepatitis B screening for pregnant women	HIV screening and counseling
Breast Cancer Mammography screenings	Osteoporosis screening	HPV DNA Test
Breast Cancer Chemoprevention counseling	Rh Incompatibility screening	Sexually Transmitted Infections counseling
Cervical Cancer screening	Tobacco Use screening and interventions, with expanded counseling for pregnant women	Well-woman visits

Preventive Services for Children who meet certain criteria, as follows:

Alcohol and drug use assessments	Developmental screening	HIV screening
Autism screening at eighteen (18) and twenty-four (24) months	Dyslipidemia screening	certain Immunizations
Behavioral assessments	Fluoride Chemoprevention supplements	Iron supplements for Children ages six (6) to twelve (12) months
Blood Pressure screening	Gonorrhea preventive medication for eyes of all newborns	Lead screening
Cervical Dysplasia screening	Hearing screening for all newborns	Medical history
Congenital Hypothyroidism screening for newborns	Height, Weight and Body Mass Index measurements	Obesity screening and counseling
Depression screening	Hematocrit or Hemoglobin screening	Oral Health risk assessment
Developmental screening	Hemoglobinopathies or sickle cell screening	PKU screening
Sexually Transmitted Infection prevention counseling and screening for high risk adolescents	Tuberculin testing	Vision screening

NOT COVERED:

- Preauthorization and approval is required for Genetic Testing.
- Certain criteria, such as age, gender or risk factors, for coverage of items listed as Preventive Care must be met as spelled out in the U.S. Government guidelines. If those criteria are not met, the item may not be covered at all or may not be covered one hundred percent (100%) in network.
- Eye Exams – Except for certain preventive care benefits for Children, these may be provided under the Vision Service Plan for Active Employees.
- Charges for physical exams for purposes of obtaining employment or insurance.
- Charges for recreational or educational therapy, or forms of non-medical self-care or self-help training, including but not limited to, health club memberships, spas and wilderness therapy.
- Charges for lenses, frames, contact lenses or other fabricated optical devices or professional Services for the fitting and/or Supply thereof (unless covered under Durable Medical Equipment or Vision Plan).
- Charges for hearing aids or professional Services for the fitting and/or Supply thereof. This Plan does have a Hearing Aid Device benefit as described on page 63.
- Labor, delivery, pre-natal and post-natal care that is Hospital-related or is not classified as "Preventive" is subject to a Deductible, Co-payment and Co-insurance. **See Inpatient Services – Facility Fees and Outpatient Services – Facility Fees** section.

- Please refer to Exclusions on page 42.

Ambulance

Covered	In-Network	Out-of-Network Coverage
Ambulance	80% (No deductible)	80% (No deductible)
Covered: • Ground and air ambulance to the nearest Facility. • Pre-authorized ambulance transfers between Hospitals or from a Hospital to a Skilled Nursing Facility.		

NOTES ON COVERAGE:

- Coverage is limited to: transportation by a licensed ambulance to the nearest Facility for either a medical emergency or for a pre-authorized Non-Emergency transfer; and pre-arranged transfers requested by a Physician.
    - **Emergency:** Emergency ambulance transportation (ground and air) by a licensed ambulance service to the nearest Hospital where emergency health Services can be performed.
    - **Non-Emergency:** Transportation by Professional Ambulance between Hospitals or from a Hospital to a Skilled Nursing Facility.
- There may be circumstances where You require medical or surgical care and You do not have the opportunity to select the ambulance. If You use an ambulance that is an Out-of-Network Provider, You are generally responsible for the difference between the Allowed Amount and the Provider's billed charges. However, in circumstances where You needed care, and were not able to choose the Provider who rendered such care, the Plan may pay an additional amount.

NOT COVERED:

- Please refer to Exclusions on pages 42-45.

Chemical Dependency

Covered	In-Network	Out-of-Network Coverage
Outpatient Services	Deductible, then 80%	Deductible, then 60%
Inpatient Services	Deductible, then 80%	Deductible, then 60%
Emergency Room Services	$100 Co-pay and Deductible, then 80% (Co-pay is not charged if admitted.)	$100 Co-pay and Deductible, then 80% (Co-pay is not charged if admitted.)
E-Visit / Telemedicine	Plan pays 100% (No Co-pay) (Teladoc only)	60% after Deductible

NOTES ON COVERAGE:

- Services may be coordinated through TEAM, if Participant so decides. See page 72.
- Outpatient charges for Chemical Dependency must be provided by a program licensed by the local Health and Human Services Department, and can include the following:
  - Diagnostic and assessment evaluations;
  - Individual, group, family, and multi-Family Therapy provided in an Outpatient setting;
  - Opiate replacement therapy including methadone and buprenorphine treatment or other equivalents (some Prescription Drug Co-pays may apply);
  - Outpatient Behavioral Health Treatment Facility charges, for Services and stays, including Intensive Outpatient Programs and related aftercare Services.
- Inpatient charges Services for Chemical Dependency must be provided during an Inpatient Stay and may include the following:
  - Detoxification Services;
  - Group and individual counseling, client education, and other Services specific to Chemical Dependency rehabilitation.
- Certain screenings and counseling for alcohol or drug use may be covered as Preventive Care.
- Smoking and Tobacco cessation counseling and classes are covered up to three (3) such sessions per year. Certain smoking cessation medications are also covered as Prescription Drugs.
- Diabetes self-management training and education, including medical nutrition therapy, for Participants diagnosed with pre-diabetes and diabetes is covered. Education for high cholesterol, hypertension, and eating disorders is also covered.

NOT COVERED:

- Preauthorization and approval is required for: Non-emergency In-patient stays, including at a Residential Facility.
- Charges for Services or confinements that are ordered by a court or law enforcement officer that are determined not Medically Necessary.
- Charges for Services to hold or confine a person under chemical influence when no medical Services are required, regardless of where the Services are received.
- Room and board charges from a half-way house, shelter, or lodging program.

- Charges for Family Therapy where the patient is not present.
- Charges for recreational or educational therapy, or forms of self-help training, including but not limited to, spas and wilderness therapy.
- Please refer to Exclusions on page 42.

Chiropractic Care

Covered	In-Network	Out-of-Network Coverage
Chiropractic Services	Deductible, then 80%	Deductible, then 60%.
Chiropractic X-ray or Diagnosis	Deductible, then 80%	Deductible, then 60%
Massage Therapy	Deductible, then 80%	Deductible, then 60%.
Acupuncture	Deductible, then 80%	Deductible, then 60%

NOTES ON COVERAGE:

- Massage Therapy is only covered if it is provided by a Chiropractor or a Licensed Massage Therapist. Massage Therapy must be for pain management, treatment of neuropathy, or for the treatment of nausea associated with surgery, chemotherapy, or pregnancy. Subject to **26 Massage Therapy visits** per Participant per Calendar Year regardless of whether the visit is In-Network or Out-of-Network.

- Subject to **26 chiropractic visits** per Calendar Year per Participant, regardless of whether visit is In-Network or Out-of-Network.

- Acupuncture is only covered if it is provided by a chiropractor or licensed Acupuncturist. Subject to **26 acupuncture visits** per Calendar Year per Participant regardless of whether the visit is In-Network or Out-of-Network. Acupuncture is limited to treatment for chronic pain and nausea associated with surgery, chemotherapy or pregnancy.

NOT COVERED:

- Please refer to Exclusions on page 42.

Dental Care as a Result of an Accidental Injury or Cancer Treatment – Physician Services

Covered	In-Network	Out-of-Network Coverage
Dental Care as a Result of an Accidental Injury or Cancer Treatment	80% coverage after Deductible	60% coverage after Deductible

Covered:

- Medically Necessary Services to treat and restore damage done to sound, natural teeth as a result of an accidental Injury that occurs while You are a Plan Participant.
  - Coverage is for damage caused by external trauma to face and mouth only, not for cracked or broken teeth that result from biting or chewing.
  - Treatment and repair must be initiated within twelve (12) months of the date of Injury and must be performed within twenty-four (24) months from the date treatment was initiated.
- Dental Implants and related services in cases of Accident or Injury.
- Dental Implants and related services for Illness, subject to a lifetime maximum benefit of $10,000.
- Treatment for Cleft Lip and Palate is limited to Services scheduled or initiated prior to the dependent Child turning age 19.

NOTES ON COVERAGE:

- Any Services in a Hospital or during an Inpatient Stay may be subject to additional Co-pays. **See Inpatient Services – Facility Fees** and **Outpatient Services – Facility Fees** sections.
- Medically Necessary surgical or non-surgical treatment of temporomandibular joint disorder (TMJ) is covered under other applicable **Schedule of Medical Benefits**.

NOT COVERED:

- Charges for any appliance or service for or related to dental implants, including Hospital charges, unless such charges are related to dental implant services for Accident, Injury and Illness when provided as a covered service.
- Bone grafts, sinus augmentations and other surgical or periodontal procedures associated with dental implants, unless such charges are related to services for Accident, Injury and Illness when provided as a covered service.
- Orthodontics (except for treatment related to Cleft Lip and Palate).
- Removable dentures.
- Dental Services and supplies rendered for treatment of the teeth, the gums (other than for tumors) or other associated structures primarily to treat 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. This exclusion shall not apply to applicable facilities fees and the technical and professional components of anesthesia fees provided in a Hospital Inpatient or outpatient setting, ambulatory surgery

center or an oral surgeon's surgery suite, where the age or physical or mental condition of the Participant or Beneficiary reasonably prevents such Services from being provided in a dentist's office.

- Please refer to Exclusions on page 26. FOR OTHER DENTAL CARE COVERAGE, GO TO THE DENTAL CARE PLAN AT PAGE 55.

Durable Medical Equipment and Supplies

Covered	In-Network	Out-of-Network Coverage
Durable Medical Equipment and Supplies	80% (No Deductible)	80% (No Deductible)

Covered:

- Wheelchairs, Hospital beds and side rails, ventilators, oxygen equipment, oxygen, continuous positive airway pressure (CPAP) devices.
- Medical supplies, which includes splints, nebulizers, surgical stockings, dressing, and catheter kits.
- Initial trusses, braces or supports; casts, splints and crutches.
- Blood, blood plasma, blood clotting factors and other fluid injected into the circulatory system.
- Covered prosthetics, plus One-time repair of a prosthetic appliance.
- Two sets of prescription Foot orthotics or inserts every two (2) years (In-Network Only).
- Initial lens(es) after surgery for cataracts and corrective lenses for aphakia.
- Enteral feedings, when the sole source of nutrition is used to treat a life-threatening condition and is Medically Necessary.
- Special dietary treatment for phenylketonuria (PKU) when prescribed/recommended by a Physician.
- Diabetic supplies (Insulins, glucometers, and related equipment and supplies only).
- Ostomy supplies.
- Phototherapy devices and/or bulbs for treatment of seasonal affective disorder (SAD).
- Kidney Dialysis equipment.
- Breast pumps purchased or rented In-Network.
- Wigs for hair loss due to alopecia areata or cancer treatment (up to Three Hundred Fifty Dollars ($350) per calendar year) and a lifetime maximum of One Thousand Four Hundred Dollars ($1,400).
- Hearing aids for Children age eighteen (18) and Younger who have a hearing loss due to a congenital malformation that cannot be corrected by other covered procedures. This is limited to one hearing aid per ear every three (3) years
- Cochlear implants.

There is a Two Thousand Five Hundred Dollars ($2,500) Hearing Aid Device benefit. See page 63.

NOTES ON COVERAGE:

- Durable Medical Equipment (DME) includes equipment purchased through a DME vendor or equipment obtained in an Inpatient setting for use in Your home or dwelling.
- Durable Medical Equipment is covered up to the Allowed Amount to rent or buy the item. Allowable rental charges are limited to the Allowed Amount to buy the item. The Plan Administrator has the right to determine whether an item will be approved for rental versus purchase.

- Diabetic supplies, other than insulin pumps, supplies for the pumps or monitoring devices, will be covered under the Prescription Drug benefits.
- Payment will not exceed the cost of an alternate piece of equipment or service that is effective and Medically Necessary.

NOT COVERED:

- Personal and convenience items or items provided at levels that exceed the Plan Administrator's determination of Medically Necessary.
- Wigs unless for alopecia areata or cancer treatment as allowed above.
- Replacement or repair of covered items, if the items are: (1) damaged or destroyed by misuse, abuse or carelessness; (2) lost; or (3) stolen.
- Labor and related charges for repair estimates of any covered items that are more than the cost of replacement by an approved vendor.
- Sales tax, mailing, delivery charges, or service call charges.
- Items that are primarily educational in nature or for vocation, comfort, convenience, or recreation.
- Modification to the structure of the home including, its wiring, plumbing, or installing equipment.
- Vehicle, car, or van modifications, including hand brakes, hydraulic lifts, and car carriers.
- Charges for Services or supplies that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement (whether or not prescribed by a Physician).
- Charges for lenses, frames, contact lenses, or other optical devices or professional Services for the fitting and/or Supply thereof. But, go to the Vision Care Plan at page 61.
- Duplicate equipment, prosthetics, or supplies.
- Nonprescription and over-the-counter charges for arch supports, foot orthotics and orthopedic shoes, including biomechanical evaluation and negative mold foot impressions.
- Enteral feedings and other nutritional and electrolyte substances, except when it is the sole source of nutrition to treat a life-threatening condition and is determined to be Medically Necessary.
- Services for or related to orthopedic shoes, except as otherwise provided in the above schedule of benefits.
- Oral dietary supplements, except for phenylketonuria (PKU).
- Other equipment and supplies the Plan Administrator determines are not eligible for coverage.
- Please refer to Exclusions on page 42.

Emergency Room and Urgent Care

Covered	In-Network	Out-of-Network Coverage
Emergency Room – Facility	$100 Co-pay and Deductible, then 80% (Co-pay is not charged if You are admitted)	$100 Co-pay and Deductible, then 80% (Co-pay is not charged if You are admitted.)
Emergency Room – Physician and Other ER Charges	80% after Deductible	80% after Deductible
Urgent Care	Deductible, then 80%	Deductible, then 60%

NOTES ON COVERAGE:

- **Emergency Medical Care:** When it appears that a condition caused by an Illness or accident requires treatment without delay to prevent serious harm, call 911 or go to the nearest Hospital Emergency Department. You do not need to notify Your Claims Administrator of a visit to an Emergency Room.

- **Urgent Care:** Urgent Care problems include Injuries or Illnesses that require urgent treatment but are not life-threatening.

- Any Outpatient or Inpatient care in a Hospital or during an Inpatient Stay may be subject to additional Co-pays. **See Inpatient Services – Facility Fees** and **Outpatient Services – Facility Fees** sections.

NOT COVERED:

- Please refer to Exclusions on page 42.

Home Health Care

Covered	In-Network	Out-of-Network Coverage
Home Health Care	80% after Deductible	60% after Deductible
Covered: Skilled Care and other home care Services ordered by a Physician and provided by employees of a Medicare approved or other preapproved Home Health Agency**.** See Notes on Coverage.		

All Home Health Care is Subject to Prior Authorization of Medical Necessity.

NOTES ON COVERAGE:

- Home Health Care is covered only when it is:
  - Medically Necessary;
  - Provided as rehabilitative or terminal care; and
  - Ordered by a Physician, and included in the written home care plan.
- Services must be provided by a Home Health Agency. A Home Health Agency is one that provides Home Health Services, is federally certified as a Home Health Agency and is licensed (if licensing is required).

- Home Health Care is one or more of the following:
  - Intermittent Skilled Nursing Services in Your home;
  - Certain Physical or Occupational therapy (Please see section entitled: Rehabilitative Service/Habilitative Services – Speech, Physical and/or Occupational therapies);
  - Care by a certified speech and language pathologist or a master's level clinical social worker.

NOT COVERED:

- Charges for Services received from a personal care attendant, or a Home Health aide.
- Services for Custodial Care.
- Home Health Services provided as Respite care for a primary care giver in the home, except where such Services are provided as Hospice Care.
- General housekeeping Services.
- Reimbursement for the above Services performed by family members or residents in the Participant's home.
- Please refer to Exclusions on page 42.

Home Infusion Therapy

Covered	In-Network	Out-of-Network Coverage
Home Infusion Therapy	80% after Deductible	60% after Deductible
Covered: Home infusion therapy Services when ordered by a Physician. See Notes on Coverage.		

NOTES ON COVERAGE:

- Home Infusion Therapy ordered by a Physician:
  - Solutions and pharmaceutical additives, pharmacy dispensing Services;
  - Durable medical equipment;
  - Ancillary medical supplies;
  - Nursing Services to train You or Your caregiver, or monitor You home infusion therapy;
  - Collection, analysis, and reporting of lab tests to monitor response to home infusion therapy; and
  - Other eligible Home Health Services and supplies provided during the course of home infusion therapy.
- Coverage is subject to routine Home Health Care reviews**.**

NOT COVERED:

- Home infusion Services not specifically listed as covered Services.
- Nursing Services to administer therapy that You or another caregiver can be successfully trained to administer.
- Services that do not involve direct patient contact, such as delivery charges and recordkeeping.
- Investigative or non-FDA approved drugs, except as required by law.
- Please refer to Exclusions on page 42.

Hospice

Covered	In-Network	Out-of-Network Coverage
Hospice	80% after Deductible	No Coverage
Covered: Hospice care for a terminal condition provided by a Medicare approved Hospice Provider or other preapproved Hospice, including routine or continuous home care.		

NOTES ON COVERAGE:

- Benefits are restricted to terminally ill patients with a terminal condition (i.e. life expectancy of six (6) months or less). The patient's primary Physician must certify in writing a life expectancy of six (6) months or less. Hospice benefits begin on the date of admission to a Hospice program with prior approval.
- General Inpatient care is for control of pain or other symptom management that cannot be managed in a less intense setting.
- Palliative Care is covered.

NOT COVERED:

- Room and board expenses in a residential Hospice Facility.
- Please refer to Exclusions on page 42.

Inpatient Services – Facility Fees

Covered	In-Network	Out-of-Network Coverage
Inpatient Services – Facility Fees	Deductible, then 80%	Deductible, then 60%

Covered:

- Semi-private room and board and general nursing care; Private room is covered only when Medically Necessary or if a semi-private room is not available.
- Intensive care and other special care units; Operating, recovery, and treatment rooms; Blood and blood products (unless replaced) and blood derivatives; Prescription Drugs or other medications and supplies used during a covered Hospital admission; Lab and diagnostic imaging; Physical, occupational, radiation, and speech therapy; General or specialty nursing care in the Hospital; Palliative Care; Transplants (organ transplants, bone marrow transplants or similar medical procedures); Take-Home Medications.

*In the event of a birth, there are separate Co-pay(s) for the Child(ren) as well as separate Deductible charges.

All In-patient Hospital Stays are subject to Prior Authorization of Medical Necessity.

NOTES ON COVERAGE:

- Surgeries requiring pre-authorization and approval:
  - Transplants.
  - Bariatric Surgery.
  - Cosmetic versus Medically Necessary procedures, such as Brow Ptosis repair, Panniculectomy, reduction Mammoplasty, Rhinoplasty, Scar excision/revision or Mastopexy.

- Hyperhidrosis surgery.
- Orthognathic surgery.
- Surgical Treatment of obstructive sleep apnea an upper airway resistance syndrome.
- Temporomandibular Joint disorder (TMJ) surgical procedures.
- Spinal cord stimulators.
- Any procedures which UMR guidelines indicate prior authorization is required.

MORE ON TRANSPLANTS:

- Please see page 38 for coverage of Transplant Services.

NOT COVERED:

- Preauthorization and approval is required for: Non-emergency In-patient stays, including at a Residential Facility.
- Please refer to Exclusions on page 42.

Maternity

Covered	In-Network	Out-of-Network Coverage
Prenatal Preventive Health Care Office Visits	100%	Deductible, then 60%
Maternity Outpatient Services	Deductible, then 80%	Deductible, then 60%
Maternity Inpatient Services	Deductible, then 80%	Deductible, then 60%
Maternity Emergency Room Services	$100 Co-pay and Deductible, then 80% (Co-pay is not charged if admitted.)	$100 Co-pay and Deductible, then 80% (Co-pay is not charged if admitted.)
Urgent Care	Deductible, then 80%	Deductible, then 60%

NOTES ON COVERAGE:

- For prenatal care benefits and certain breastfeeding support benefits, refer to Preventive Care at page 32.
- Prenatal Preventive Health Office Visits include prenatal office visits that deal with non-routine diagnoses in the pregnancy.
- Two ultrasounds are covered one hundred percent (100%) as preventive care; additional ultrasounds are subject to Deductible and Co-insurance.
- Refer to the Eligibility section to determine when the baby's coverage begins.
- Mother and Child are separate Participants under the Plan. For Services or charges related to a birth (outside of Preventive Care), there are separate Co-Pay(s) and separate Deductibles for the Mother and the Child/ren.
- The Plan covers one (1) Home Health care visit within four (4) days of discharge from the Hospital.
- Health care professional charges of a certified midwife for deliveries in the home.
- Postpartum labs and imaging are subject to Deductibles and Co-insurance.

NOT COVERED:

- Services for or related to Surrogate pregnancy for the Surrogate mother and the Child/ren born in a Surrogate Pregnancy, including diagnostic screening, Physician Services, reproduction treatments, prenatal/delivery/postnatal Services. A Surrogate Pregnancy is a pregnancy where the mother enters into a contract or other understanding pursuant to which she relinquishes the Child following its birth.
- Services for or related to adoption fees.
- Doula charges.
- Services and prescription drugs for treatment of infertility.
- Charges for the long-term storage of ova or sperm or the donation of ova or sperm.
- Please refer to Exclusions on page 42.

Mental Health

Covered	In-Network	Out-of-Network Coverage
MH Outpatient Services	Deductible, then 80%	Deductible, then 60%
MH Inpatient Services	Deductible, then 80%	Deductible, then 60%
MH Emergency Room Services	$100 Co-pay and Deductible, then 80% (Co-pay is not charged if admitted.)	$100 Co-pay and Deductible, then 80% (Co-pay is not charged if admitted.)
Urgent Care	Deductible, then 80%	Deductible, then 60%
E-Visit / Telemedicine	Plan pays 100% (No Co-pay) (Teladoc only)	60% after Deductible

NOTES ON COVERAGE:

- Services may be coordinated through TEAM. See page 72.
- Outpatient charges can include the following:
  - Diagnostic and assessment evaluations;
  - Individual, group, family, and multi-Family Therapy provided in an Outpatient setting;
  - Neuro-psychological;
  - Outpatient Behavioral Health Treatment Facility charges, for Services and stays, including crisis evaluations and related aftercare Services.
  - Hospital-based partial programs
  - Hospital-based Day Treatment
  - Hospital-based Intensive Outpatient Programs
- Inpatient charges Services must be provided during an Inpatient Stay and may include the following:
  - Emergency holds
- All mental health treatment must be provided by a licensed Mental Health Professional operating within the scope of his or her license.
- Certain screenings are covered as Preventive Care.

- Diabetes self-management training and education, including medical nutrition therapy, for Participants diagnosed with pre-diabetes and diabetes is covered. Education for high cholesterol, hypertension, and eating disorders is also covered.

NOT COVERED:

- Preauthorization and approval is required for: Non-emergency In-patient stays, including at a Residential Facility.
- Services for mental Illness not listed in the most recent editions of the *International Classification of Diseases (ICD) and Diagnostic and Statistical Manual for Mental Disorders (DSM).*
- Family Therapy where patient is not present.
- Charges for marital, relationship, family or other counseling or training Services, religious counseling, or sex therapy rendered in the absence of a significant mental disorder.
- Charges for Services or confinements ordered by a court or law enforcement officers that are determined not Medically Necessary.
- Charges for recreational or educational therapy, or forms of self-help training, including but not limited to, spas and wilderness therapy.
- Room and board charges for half-way house, shelter care, or lodging program.
- Please refer to Exclusions on page 42.

Outpatient Services – Facility Fees

Covered	In-Network	Out-of-Network Coverage
Surgical Outpatient	Deductible, then 80%	Deductible, then 60%
Nonsurgical Outpatient including Ultrasound, MRI, CT and other scans; stress tests; dialysis; chemotherapy; respiratory therapy; Palliative Care	Deductible, then 80%	Deductible, then 60%
Allergy testing, serum and injections in an office or urgent care setting	100%	Deductible, then 60%

COVERED:

- Surgeries requiring pre-authorization and approval:
    - Bariatric Surgery.
    - Cosmetic versus Medically Necessary procedures, such as Brow Ptosis repair, Panniculectomy, reduction Mammoplasty, Rhinoplasty, Scar excision/revision or Mastopexy.
    - Hyperhidrosis surgery.
    - Orthognathic surgery.
    - Surgical Treatment of obstructive sleep apnea an upper airway resistance syndrome.
    - Temporomandibular Joint disorder (TMJ) surgical procedures.

- Spinal cord stimulators.
- Any procedures which UMR guidelines indicate a prior authorization is required.

- Two ultrasounds per pregnancy are covered one hundred percent (100%) as preventive care. Subsequent ultrasounds are subject to Deductible and Co-insurance.

NOT COVERED:

- Charges for recreational or educational therapy, or forms of self-help training, including but not limited to, spas and wilderness therapy.

- Please refer to Exclusions on page 42.

Physician Services

Covered	In-Network	Out-of-Network Coverage
Office Visits To Physician	80% after Deductible	60% after Deductible
Physician Services to Participant During In-Patient Stay	80% after Deductible	60% after Deductible
ER Physician	80% after Deductible	80% after Deductible
E-Visit	$10 Co-pay, then Plan pays 100% July 1, 2017, Plan pays 100% (No Co-pay) (Teladoc only)	60% after Deductible.
Covered: Office visits for Illness; Hearing aid exams; Lab and diagnostic imaging; Allergy testing and injections; Surgery; Anesthesia, Pathology. **Allergy Testing, Serum and Injections** in an office or urgent care setting are covered one hundred percent (100%) if In-Network. If Out-of-Network, according to the above schedule.		

NOTES ON COVERAGE:

- Diabetes self-management training and education, including medical nutrition therapy, for Participants diagnosed with pre-diabetes and diabetes is covered. Education for high cholesterol, hypertension, and eating disorders is also covered.

- Certain Surgeries require Preauthorization and Approval. **See Inpatient Services – Facility Fees** and **Outpatient Services – Facility Fees** sections.

NOT COVERED:

- Charges for treatment not within the scope of the Physician's license.

- Please refer to Exclusions on page 42.

Rehabilitative Services / Habilitative Services – Speech, Physical and/or Occupational Therapies

Covered	In-Network	Out-of-Network Coverage
Rehabilitative Services / Habilitative Services	80% after Deductible	60% after Deductible
Covered: Rehabilitative physical and occupational therapy Services received in a clinic, office, or outpatient Facility, subject to the Exclusions section in this Plan. Speech therapy is also covered, subject to Plan exclusions.		

NOTES ON COVERAGE:

- Prior Authorization is required, after twenty-six (26) visits. for twenty-five (25) visits. Additional visits beyond 25 are subject to an additional Medically Necessity determination.
- Physical, occupational and/or speech therapy Services are covered if the rehabilitative care is to correct the effects of Illness or Injury or if the rehabilitative care is rendered for congenital, developmental, or medical conditions that have limited the successful initiation of normal speech and motor development. To be considered rehabilitative, functional improvement and measurable progress must be made toward achieving functional goals within a predictable period of time toward a Participant's maximum potential ability.
- Rehabilitative therapy is covered to restore function after an Illness or Injury provided for the purpose of obtaining significant functional improvement within a predictable period of time, toward a Participant's maximum potential to perform functional daily living activities.
- Physical therapy, occupational therapy and/or speech therapy must be ordered by a Physician.
- Applied Behavior Therapy is covered when medically necessary.
- Habilitative Care is Medically Necessary health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning that are necessary to address a health condition to improve skills and functioning for daily living

NOT COVERED:

- Charges for recreational or educational therapy, or forms of non-medical self-care or self-helping training, including, but not limited to, health club memberships, spas and wilderness therapy.
- Charges for maintenance or custodial therapy; charges for rehabilitation Services that are not expected to make measurable or sustainable improvement within a reasonable period of time.
- Non-covered therapies include, but are not limited to self-care, home management training (activities of daily living) and compensatory training, meal preparation, safety procedures, and instructions in the use of adaptive equipment; community/work reintegration training (shopping, transportation, money management, vocation activities and/or work environment/modification analysis, work task analysis) and work hardening/conditions.
- Please refer to Exclusions on page 42.

Skilled Nursing Facilities

Covered	In-Network Coverage	Out-of-Network Coverage
Skilled Nursing Facilities	80% after Deductible	60% after Deductible

Covered:

- Skilled Care ordered by a Physician and eligible under Medicare guidelines;
- Semi-private room and board; Private room if Medically Necessary;
- General nursing care;
- Prescription Drugs or other medications and supplies used during a covered admission, and billed through the Skilled Nursing Facility;
- Physical, occupational speech therapy;
- Palliative Care;
- Respiratory therapy.

All Skilled Nursing Stays are subject to Prior Authorization.

NOTES ON COVERAGE:

- To be eligible for coverage, confinement must begin within thirty (30) days of discharge from the Hospital for the same or related Illness (after confinement of at least three (3) days).

NOT COVERED:

- Preauthorization is required for: Non-emergency In-patient stays, including at a Residential Facility.
- Please refer to Exclusions on page 42.

Transplant Services

Benefit	In-Network Coverage	Out-of-Network Coverage
Transplant Services	Deductible, then 80%	None

Covered:

If the Transplant is at a provider approved by Optum Transplant Resource Services (TRS); the Plan covers the Transplant at one hundred percent (100%) with no deductible. The Plan will also cover one hundred percent (100%) of the cost of travel and lodging up to Two Hundred Dollars ($200) per day to go to the nearest TRS provider for the type of transplant being provided.

Transplants and certain related Services for the following:

- Heart.
- Heart and Lung.
- Liver (cadaver and living).
- Lung (single or double).
- Bone Marrow/Stem Cell.
- Artery/vein transplants.
- Pancreas Transplants.
- Heart valve replacements.
- Small bowel or small bowel/liver.

NOTES ON COVERAGE:

- Pre-Authorization is required for a Transplant.
- Contact Your Claims Administrator for limitations and other details.
- Hospital Inpatient or outpatient Services may be subject to additional Co-pays. **See Inpatient Services – Facility Fees** and **Outpatient Services – Facility Fees** sections.
- Organ Transplants are only covered if they are In-Network.
- The Plan reserves the right to require the Participant or Beneficiary to have the transplant procedure performed at a hospital or other medical Facility designated by the Plan.
- Kidney transplants and Cornea Transplants are covered as an Illness, and not under this section.

NOT COVERED:

- Donor expenses when recipient is not covered under this Plan.
- Donor complications after organ is removed when recipient is not covered under this Plan.
- Please refer to Exclusions on page 42.

Prescription Drug Benefits

The Plan participates with a pharmacy benefit manager CVS Caremark, who manages a Formulary for prescription drug purchases. The pharmacy benefit manager uses its drug Formulary to determine which prescription drugs, including their generic equivalents, are covered. The Co-payments and Co-insurance for Formulary drugs are listed in the Schedule of Benefits below. The pharmacy benefit manager's Formulary is updated often.

Non-formulary drugs are not covered. If a prescription drug is for a non-covered diagnosis, there is no benefit available.

Specialty drugs or specialty medications are both oral and self-injectable medications dispensed by a specialty pharmacy. These medications generally require special storage or handling. Specialty medications may be self-administered (e.g., injectable) medications or medications administered at a Doctor's office. There is NO COVERAGE for specialty drugs, unless such drugs are obtained through the specialty pharmacies specified by the Plan's pharmacy benefit manager CVS. The Specialty Network is currently the CVS Exclusive Specialty + Network.

The Plan excludes certain compound bulk chemicals, pain patches and compound kits, which is where ingredients of a drug are combined, mixed or altered with another drug or several other drugs to create medication. The Plan's pharmacy benefit manager may also authorize a split-fill (not a full thirty (30)-day prescription) on certain oral oncology drugs. The Plan's pharmacy benefit manager may require pre-authorization and/or quantity limits on drugs used to treat pain or ADHD.

The Plan uses CVS Caremark, to provide for a network of covered pharmacies that fill or dispense prescriptions. To find a covered pharmacy, go to www.caremark.com or call Wilson-McShane Corporation.

No prescription drug benefits will be payable for any charges incurred by an individual who is enrolled in Medicare Part D.

Restrictions for Prescription Medications to Prevent Misuse and Abuse

Plan Trustees reserve the right to protect the Plan from the potential misuse and abuse of prescription controlled substance medications by restricting Plan Participants to one Physician for all basic medical care and/or one pharmacy for the filling of all prescriptions. The Plan may impose this restriction when records show a Participant is obtaining prescriptions from more than one Doctor for the same or similar controlled substance medications and/or filling the same or similar prescriptions at more than one pharmacy. Restrictions shall be twelve (12) months in length, subject to renewal at the Plan Trustees' discretion.

The Plan will provide notice to Participants indicating: (1) the effective dates of the restriction(s); (2) the name, address and phone number for the assigned Physician and/or pharmacy; or as an alternative, the Participant may choose one Physician and one pharmacy to be used. The Participant's choice is subject to approval by the Plan; and (3) a procedure by which to file a request for reconsideration.

A Participant who fails to adhere to the restrictions will be one hundred percent (100%) responsible for the costs of all controlled substance medications.

Prescription Drugs

Covered	In-Network	Out-of-Network Coverage
Formulary Drugs at a Retail Pharmacy (up to a thirty-one (31)-day Supply)	Greater of $8 Co-pay or 20% ($100 maximum per prescription)	Plan pays negotiated rate*** minus greater of $8 Co-pay or 20%; You pay difference ($100 maximum per prescription)
Formulary Drugs at Mail Order Pharmacy (up to a ninety (90)-day Supply)	Greater of $16 Co-pay or 20% ($200 maximum per prescription)	**No coverage**
Non-Formulary Drugs at Retail Pharmacy	**No coverage**	**No coverage**
Non-Formulary Drugs at Mail Order Pharmacy	**No coverage**	**No coverage**
Prescribed PPI /NSAH over-the-counter (OTC) drugs	100%	**No coverage**
Specialty Drugs purchased at a Specialty Pharmacy Network Supplier (CVS Exclusive Specialty + Network)	Greater of the $8 (retail) or 20% ($100 maximum per prescription) or $16 (mail order) Co-pay or 20% ($200 maximum per prescription)	**No coverage**
NOTE: Go to page 18 **for information on Prescription Drug Annual Out-of-Pocket (OOP) Limits**		

NOTES ON COVERAGE:

- Reimbursement is for drugs requiring a written prescription by a Physician and must be dispensed by a licensed pharmacist or Doctor.
- The Formulary is a comprehensive list of preferred drugs selected by the Plan's pharmacy benefit manager. The drug Formulary serves as a guide for the Provider community by identifying which drugs are covered. It is updated regularly and includes brand name and generic drugs.
- Non-Formulary drugs are not on the Plan's pharmacy benefit manager list of Formulary drugs, and Non-Formulary drugs are not covered.
- Diabetic meters and pumps are covered as a Durable Medical Equipment Expense. **See Durable Medical Equipment and Supplies**.
- Dispense as written (DAW) does not override the generic requirement.
- Dispense as written (DAW) does not override the Non-Formulary Co-payment.
- Certain smoking cessation medications are covered.
- The Plan's pharmacy benefit manager may also authorize only a split-fill (not a full thirty (30)-day prescription) on certain oral oncology drugs.
- The Plan's pharmacy benefit manager may require pre-authorization and/or quantity limits on drugs used to treat pain or ADHD.
- Step Therapy – The Fund has added a Step Therapy Program for certain medications, including cholesterol-lowering and proton pump inhibitor (PPI) drugs. This Program uses a "step" approach to select the drugs the Plan will cover to treat Your condition. This means You may first need to try a clinically appropriate, cost-effective drug before other more costly drugs are approved for payment.

- Effective June 1, 2022, the Plan has contracted with CVS/Caremark and PrudentRx to provision a non-needs-based copay assistance program for specialty medications. These copay assistance programs provide financial assistance on a drug specific and manufacturer sponsored basis. PrudentRx provides Participants awareness of these assistance programs and helps facilitate enrollment in such programs as they are available.

    - Medications on the PrudentRx drug list are included in the program but are subject to the Plan's coverage parameters and requirements as applicable. Participants enrolled with PrudentRx will have $0 out-of-pocket responsibility even in the absence of a copay card assistance program. Participants not enrolled with PrudentRx will be responsible for any applicable co-insurance (30%).

    - Go to https://www.prudentrx.com/prudentexs/ to see a current list of specialty medications that are offered through PrudentRx. Please note that this list may be subject to change. PrudentRx requires the use of CVS/Specialty unless the product(s) used are noted under the "LIMITED DISTRIBUTION*" section of the above PrudentRx drug list. For these products you will continue to use the current dispensing pharmacy.

    - If you currently take one or more of the specialty medications included in the PrudentRx Drug List, you will receive a welcome letter and phone call from PrudentRx that provides specific information about the program, provided your contact information is on file. Participants must call PrudentRx at 1-800-578-4403 to register for manufacturer copay assistance through the program as some drug manufacturers require you to register with them before they provide copay assistance for their medications.

    - Please note that any copay assistance provided by PrudentRx will not count toward your annual prescription drug out-of-pocket maximum. If you decline enrollment in the PrudentRx Solution for any reason, you will be responsible for the full amount of coinsurance on your specialty medications that would have been covered had you so enrolled.

NOT COVERED:

- The cost of administering the drugs, unless specifically covered under the medical portion of the Plan.
- The drugs that the federal government has not approved for sale.
- Charges for nonprescription (over-the-counter) drugs or medicines; vitamins or treatment; nutritional supplements; over-the-counter appetite suppressants; prescription drugs classified as less than effective by the FDA; biotechnological drug therapy that has not received FDA approval for the specific use being requested, except for off-label use in cancer treatment as specified by law; or prescription drugs that are not administered according to generally accepted standards of practice in the medical community.
- Compound bulk chemicals, pain patches and compound kits. These are where ingredients of a drug are combined, mixed or altered with another drug or several other drugs to create medication.
- Informational materials.
- Smoking cessation gum, patch or related items, unless prescribed by a Physician.
- Please refer to Exclusions on page 42.

Health & Fitness Reward$ Program

You have access to United Healthcare's Health & Fitness Rewards Program. The program allows you to receive a partial reimbursement for a gym membership. Contact Wilson-McShane Corporation for more details about the program.

Real Appeal Weight Loss Support

A weight loss support program called Real Appeal is available to you through United Healthcare. The program is online and free to you. Real Appeal provides you with assistance in setting your nutrition, exercise and weight loss goals. You can go to: enroll.realappeal.com to enroll and get started in the program.

General Exclusions for the Medical Plan

The **Medical Plan** does not pay for and excludes from benefits:

1. Charges for any treatments, Services, or supplies that are determined not **Medically Necessary**.
2. Charges for any treatment, Service, or Supply that are determined to be **Experimental or Investigative** unless required by law.
3. Charges which are in excess of the **Allowed Amount**.
4. Charges for Services that are eligible for payment under a **Workers' Compensation** law, employer liability law, or any similar law.
5. Charges that are eligible, paid, or payable under any medical payment, personal Injury protection, automobile, homeowner's **policy or other coverage** that is payable without regard to fault, including charges for Services that are applied toward any Co-payment or Co-insurance requirement of such a policy.
6. Charges incurred as a result of any automobile accident where You fail to maintain the statutory minimum level of no-fault automobile medical insurance protection, provided that the eligible individual is required by the Minnesota Statutes to maintain said coverage.
7. Services that are rendered to a Participant who also has **other primary insurance coverage** for those Services and who does not provide the Plan Administrator the necessary information to pursue coordination of benefits, as required by the Plan.
8. The portion of eligible Services and supplies paid or payable under **Medicare**, subject to the Medicare Secondary Payer rules.
9. Charges for **Cosmetic** surgery, unless required because of:
    a. An accidental bodily Injury occurring while covered under this Plan if treatment begins within ninety (90) days from the date of such accident;
    b. Reconstructive surgery when service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part covered by this Plan;
    c. Reconstructive surgery due to congenital disease or anomaly of a dependent Child covered by this Plan which has resulted in a functional defect; or
    d. As required to be allowed by federal law.
10. Charges for **Custodial Care**.
11. Services for or related to treatment of Illness or Injury, which occurs **while on military duty** that are recognized by the Veteran's Administration as Services related to service-connected Injuries.
12. Charges for **therapeutic acupuncture or therapeutic massage** except as provided in the **Schedule of Medical Benefits**.

13. Charges for **marital, family or other counseling** or training Services, religious counseling as indicated in the **Schedule of Medical Benefits**.

14. Charges for **recreational or educational therapy**, or forms of non-medical self-care or self-help training, including, but not limited to, health club memberships, spas or wilderness therapy.

15. Expenses incurred for Services, supplies, medical care or treatment received at a health care Provider that represents to patient that he or she will not owe the required cost sharing amount (including, for example, Deductibles, Co-payments, and Co-insurance) described in this Plan SPD.

16. Services for or related to **transcranial magnetic stimulation therapy**.

17. Services related to the **LINX™** Reflux Management System for the treatment of gastroesophageal reflux disease (GERD).

18. Charges for **lenses, frames, contact lenses** or other fabricated optical devices or professional Services for the fitting or Supply thereof. These items may be covered under the Vision Plan, starting at page 61.

19. Charges for **Lasik**, keratotomy, keratorefractive or hyperophia surgeries or procedures.

20. Charges for Services that are **normally provided without charge**, including Services of the clergy.

21. Charges for **autopsies**.

22. Charges for **vitamins** or vitamin therapy, except provided in the **Schedule of Medical Benefits**.

23. **Donor charges** for major organ and bone marrow transplants when the recipient is not covered under the Plan; including all transplant-related follow-up treatment, exams, drugs and drug therapies, and complications from transplants.

24. Charges for **Services a Provider gives him/herself or a close relative** (such as Spouse, brother, sister, parent, or Child).

25. Charges for Services related to **dental or oral care, orthodontics, or surgery** and any related supplies, anesthesia or Facility charges, except for those specified in the **Schedule of Medical Benefits** or as provided in the Dental Care Plan, starting at page 55.

26. Charges for **personal comfort items** such as telephone, television, barber, beauty Services, and guest Services.

27. Charges for **wigs**, unless for alopecia areata or hair loss due to chemotherapy treatments as allowed in the **Schedule of Medical Benefits**.

28. **Hospital Room and Board Charges for a private room,** unless a private room is determined Medically Necessary.

29. Charges for Services and supplies that are primarily and customarily **used for a nonmedical purpose or used for environmental control or enhancement** (whether or not prescribed by a Physician) including, but not limited to, exercise equipment, air purifiers, air conditioners, dehumidifiers, heat/cold appliances, water purifiers, hypoallergenic mattresses, waterbeds, vehicle lifts, computers and related equipment, car seats, feeding chairs, pillows, food or weight scales, hot tubs, home blood pressure kits, swimming pools, whirlpools, incontinence pads or pants, thermometers, and elastic bandages or stockings.

30. Charges for or related to **transportation other than ambulance service** to the nearest medical Facility equipped to treat the Illness or Injury, except as specified in the **Schedule of Medical Benefits** section.

31. Charges for **travel, transportation, or living expenses,** whether or not recommended by a Physician.

32. Charges for **Services provided before Your coverage is effective or after Your coverage terminates** even though Your Illness started while coverage was in force.

33. Charges for **private-duty nursing**.

34. Charges for **weight loss programs** that are not Medically Necessary for the treatment of obesity; coverage is limited to treatment obtained from professional weight loss doctors, nurses and registered dieticians. This exclusion does not apply to office visits and diagnostic tests for the treatment of obesity; gastric restrictive procedures, gastric malabsorptive procedures, and combination restrictive and malabsorptive procedures for the treatment of morbid obesity; and nutritional counseling Services billed by a covered Provider.

35. Charges for **maintenance** rehabilitative therapy, exercise programs, recreational or educational therapy, wilderness therapy and hippotherapy (exercise on horseback).

36. Therapy submitted under procedure codes 97535, 97537 and 97545. Therapies including but not limited to self-care, home management training (activities of daily living) and compensatory training, meal preparation, safety procedures, and instructions in the use of adaptive equipment; community/work reintegration training (shopping, transportation, money management, vocation activities and/or work environment/modification analysis, work task analysis) and work hardening/conditions.

37. Charges for **reversal of sterilization**.

38. Charges for **long-term storage of ova or sperm**, or for the donation of ova or sperm.

39. Services and prescription drugs for treatment of infertility.

40. Services for or related to **Surrogate Pregnancy** for the surrogate mother and the Child/ren born in a Surrogate Pregnancy, including diagnostic screening, Physician Services, reproduction treatments, prenatal/delivery/postnatal Services. A Surrogate Pregnancy is a pregnancy where the mother enters into a contract or other understanding pursuant to which she relinquishes the Child following its birth.

41. Services for or related to **adoption fees**.

42. Charges for an **induced termination of a pregnancy** unless it is determined by the attending Physician to be Medically Necessary; however, complications resulting from such a termination of a pregnancy are covered as any other Illness.

43. **Nutritional supplements**, over-the-counter electrolyte supplements, and infant formula, except for PKU treatment.

44. Services for or related to **functional capacity evaluations** for vocational purposes and/or determination of disability or pension benefits.

45. Charges for treatment, equipment, drugs, and devices that are determined not to meet generally accepted standards of practice in the medical community for cancer and allergy testing and treatment.

46. Charges for physical exams for the purpose of obtaining employment, licensure, or insurance.

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

48. Any care or treatment of an eligible individual once the individual has already received Plan benefits totaling the maximum benefit for the type of care and treatment as specified on the **Schedule of Medical Benefits**.

49. **Communication devices**, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate.

50. Charges for furnishing medical records or reports, including any charges for completing of 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.

51. Charges for failure to keep scheduled visits.

52. Services that do not involve direct patient contact, such as delivery charges and recordkeeping.

53. 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 or the illegal occupation or felonious act is related to a physical or mental health condition.

54. Services that are prohibited by law or regulation.

55. Services for or related to **chelation therapy** that are determined not Medically Necessary.

56. Services for or related to **homeopathy**.

57. Services for or related to **growth hormone**, except that replacement therapy is eligible for conditions that meet Medical Necessity.

58. **Dentures**, regardless of the cause or condition, and any associated Services and/or charges including bone grafts, except as provided in the **Schedule of Medical Benefits**. Some items may also be covered under the Dental Care Plan at page 58.

59. Services for or related to orthopedic shoes, except for up to two pair of Medically Necessary arch supports or shoe inserts every two years.

60. Charges for any Injury sustained while participating in a high-risk activity or participating in an extreme sport unless the Injury results from a medical condition or domestic violence.

61. Charges to repair or replace Durable Medical Equipment due to neglect, abuse, loss, or theft of the equipment.

62. Charges for purchase or rental of an electric breast pump from an Out-of-Network Provider.

64. Any loss, expense or charge arising from the maintenance or use of an automobile where (a) you fail to maintain the statutory minimum level of no-fault insurance required by the State in which you reside (for example: $20,000 in Minnesota); (b) where you fail to apply for the no-fault benefits available to you; (c) where a no-fault insurer has determined charges not to be Medically Necessary or exceed the Allowed Amount; or (d) you do not first exhaust any no-fault coverage available to you.

65. Any loss, expense or charge arising from the maintenance or use of an automobile in non-no fault states where (a) you failed to maintain the statutory minimum level of applicable automobile medical and/or disability insurance protection in the jurisdiction in which you reside (this exclusion will apply only up to the amount of automobile medical and/or disability insurance so required); (b) you failed to apply for any available automobile medical and/or disability insurance; (c) the automobile insurer has determined that charges are not Medically Necessary, exceed the Allowed Amount; or (d) you do not first exhaust any medical payment and/or disability coverage on the vehicle(s) involved in the accident.

66. Any loss, expense or charge for any Injury or Illness that results from an event occurring on any property where a lessee, lessor, or owner of the property is responsible for the Injury or Illness or where the loss, expense or charge is otherwise covered under homeowner's insurance on the property. The Plan may pay the loss, expense or charge only if (a) no insurance or other form of compensation is available to you; and (b) you (or other individual legally responsible for payment of expenses) signs an acknowledgment of the Plan's first priority right to subrogation and reimbursement.

67. The Medical Plan does not pay for and excludes from benefits any medical and/or prescription drug charges for or related to gene therapy, regardless of whether those therapies have received approval from the U.S. Food and Drug Administration (FDA) or are considered experimental or investigational. Gene therapy generally involves replacing or editing a gene to help the body compensate for abnormal genes or to make a beneficial protein. Some examples of gene therapy include, but are not limited to, Chimeric Antigen Receptor T-Cell (CAR-T) Therapies such as Kymriah and Yescarta, as well as other therapies, such as Luxturna and Zolgensma.

Notice of Rights Under the Federal Women's Health and Cancer Rights Act of 1998

The Federal Women's Health and Cancer Rights Act of 1998 requires group health plans such as this Plan to provide certain benefits if a Participant chooses reconstructive surgery after a mastectomy. The federal law requires coverage for the following Services:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.

Prosthesis and treatment for physical complications during all stages of mastectomy, including swelling of the lymph glands (lymphedema).

Services are provided in a manner determined in consultation with the Physician and patient. Coverage is provided on the same basis as any other Illness.

Notice of Rights Under Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans such as this Plan generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than forty-eight (48) hours following a vaginal delivery or to less than ninety-six (96) hours following a caesarean section. However, the Plan may pay for a shorter stay if the attending Provider (e.g., Your Physician, nurse midwife or Physician assistant), after consultation with the mother discharges the mother or her newborn Child earlier than forty-eight (48) hours or ninety-six (96) hours, as applicable.

Also, the Plan may not set the level of benefits or Out-of-Pocket costs so that any later portion of the forty-eight (48)-hour (or ninety-six (96)-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, the Plan may not require that a Physician or other health care Provider obtain authorization for prescribing a length of stay of up to forty-eight (48) hours (or ninety-six (96) hours). However, to use certain Providers or facilities, or to reduce Your Out-of-Pocket costs, You may be required to obtain pre-approval. For information on pre-approval, please contact the Plan Administrator.

Information Regarding Genetic Information

This Plan shall not request or require a Participant to undergo a genetic test. However, this Plan may obtain and use the results of a genetic test in making payment determinations as allowed in Internal Revenue Code §9802(c)(3) or for research purposes as allowed in Code §9802(c)(4).

This Plan shall not request, require or purchase Genetic Information with respect to any individual prior to enrollment or for underwriting purposes. Nor shall this Plan require a Participant or contributing Employer to pay an additional premium or contribution as a condition of enrollment or continued enrollment based on Genetic Information, provided that this provision is not to be construed as limiting the amount the Plan may charge contributions to the Plan.

How to File a Medical Benefits Claim

Types of Medical Claims

There are different types of claims as explained below:

If a claim is denied or reduced, You must follow the appeal process to have Your claim reviewed.

- A claim is any request for a Plan benefit. A "Medical Claim" is one seeking coverage under the Medical Benefits portion of the Plan.
- There are four types of medical claims, each with different timeframes for claims and appeals:
    - A pre-service claim is any request for a benefit, where the Plan requires advance approval in order to receive the full benefit.
    - An urgent care claim is a pre-service claim, where there is time urgency. If the patient's life is seriously jeopardized then there is no need to seek advance approval – all that is required is notification after admittance to the Hospital. If the patient requires immediate care to provide pain management or to save full functionality, as determined by a Physician, then this is an urgent care claim and the preauthorization can be obtained over the phone.
    - A concurrent care claim is one in which a treatment was approved for a specific time period or number of treatments and now needs to be extended, reduced, or terminated.
    - A post-service claim is a claim that is not a pre-service or urgent care claim.

Where to File Claims

Urgent Care Claims

An Urgent Care Claim may be submitted to UMR by telephone toll free at 11-866-494-4502. Urgent care claims will be decided within seventy-two (72) hours. Concurrent claims that extend treatment must be made at least twenty-four (24) hours before the end of the pre-authorized course of treatment.

Pre-Service Claims

A Pre-Service Claim (including a Concurrent Care Claim that is also a Pre-Service Claim) is considered filed when the request for approval of treatment or Services is made and received by the Claims Administrator. Pre-Service claims will be decided within fifteen (15) days.

Post-Service Claims

If You receive Services from Non-Network Providers, You may have to submit the claim Yourself. If the Provider does not submit the claim for You, send the claim to UnitedHealthcare at the address provided below:

UnitedHealthcare
P.O. Box 30518
Salt Lake City, UT, 84130-0518

Deadline for Filing Claims

Claims should be filed in writing within ninety (90) days after a covered service is provided. If this is not reasonably possible, claims will be accepted up to twelve (12) months after the date of service. Normally,

failure to file a claim within the required time limits will result in denial of Your claim. These time limits are waived if You cannot file the claim because You are legally incapacitated. You may be required to provide copies of bills, proof of payment, or other satisfactory evidence showing that You have incurred a covered expense for reimbursement.

Notification of Initial Benefit Decision

The Claims Administrator will provide You with notice of initial benefit decision on a claim, which may be (a) approval, denial, reduction, or termination of, or (b) a failure to provide or make payment (in whole or in part) for a benefit. The Claims Administrator will provide You with a written notice of the decision on a Pre-Service or Urgent Care Claim regardless of the decision. The Claims Administrator may provide You with oral notice of a benefit determination on an Urgent Care Claim, but written notice will be furnished no later than three (3) days after the oral notice. For a Post-Service Claim, written notice will be provided within thirty (30) days of the date Your claim is received. If, due to matters beyond the Plan's control, the Plan is unable to make a determination within thirty (30) days, the Plan may take an additional fifteen (15) days to make a determination and will inform You in advance of the reasons for the extension. If You do not receive a written explanation within thirty (30) days (or forty-five (45) days if there have been an extension), You may consider the claim denied. You may treat any partial denial or denial of a claim as an adverse benefit decision entitled to appeal and review as described at pages 51, 52, 53 and 54. You are also entitled to ask for information and explanations of the denials as described in the next section, *Explanation of Medical Benefits*.

Explanation of Medical Benefits

You may also be notified of the resolution of a claim for Medical Benefits on an Explanation of Benefits (EOB) form.

If Your claim for Medical Benefits is denied in whole or in part, the reason for the denial will be listed on the bottom of the EOB form. You have the right to know the specific reasons for the denial, the provision of the Plan on which the denial was based, and if there is any additional information needed to process the claim. You also have the right to an explanation of the claim appeal and review procedure and the steps You need to take if You wish to have Your claim reviewed. If You have questions that the EOB form does not answer, please contact the Claims Administrator at the address or phone numbers shown below:

Wilson-McShane Corporation
1330 Conway Street, Suite 130
St. Paul, MN 55106
952-851-5949
800-535-6373

Any partial or full denial of a claim provided on an EOB is an adverse benefit determination entitling You to appeal and review as provided at pages 50, 51 and 52.

Incomplete Claims

If any information needed to process a claim is missing, the claim will be treated as an incomplete claim. If an Urgent Care Claim is incomplete, the Claims Administrator will notify You as soon as possible, but no later than twenty-four (24) hours following receipt of the incomplete claim. The notice will explain that the claim is incomplete, describe the information necessary to complete the claim and specify a reasonable time, no less than forty-eight (48) hours, within which the claim must be completed. The notice may be oral unless You specifically request written notice. The Claims Administrator will decide the claim as soon as possible but no later than forty-eight (48) hours after the earlier of: (a) receipt of the specified information; or (b) the end of the period provided to submit the specified information.

If a Pre-Service or Post-service Claim is incomplete, the Claims Administrator will notify You as soon as possible. The notice will explain that the claim is incomplete and describe the information needed to complete the claim. The timeframe for deciding the claim will be suspended from the date You receive the notice until the date the necessary information is provided to the Claims Administrator. The Claims Administrator will decide the claim following receipt of the requested information and provide You with written notice of the decision.

Right of Examination

You may be asked to be examined by a Provider during the review of any claim. UMR chooses the Provider and pays for the exam whenever it is requested. Failure to comply with this request may result in denial of Your claim.

Release of Records

You agree to allow all health care Providers to give the needed information about the care they provide to You. This information may be needed to process claims, conduct utilization reviews, care management, and quality improvement activities, and for other health plan activities as permitted by law. This information is kept confidential, but may be released if You authorize release, or if state or federal law permits or requires release without Your authorization. If a Provider requires special authorization for release of records, You agree to provide this authorization. Your failure to provide authorization or requested information may result in the denial of Your claim.

Legal Actions

No legal action may be brought related to the denial of a medical claim after the expiration of three years from Your initial request for coverage of the medical expenses was made.

No Assignment of Claim and/or Appeal and/or Right to Sue

Coverage and Your rights and causes of action under the Plan may not be assigned. A direction to pay a Provider is not an assignment of Your rights under this Plan nor is it an assignment of any of Your legal or equitable rights to institute any court proceeding. No Participant or Beneficiary may assign to a Provider: (a) his or her right to file an appeal under the Plan's claims and appeal procedure; or (b) his or her right to file a suit for benefits under Section 502 of ERISA, with the exception of an Urgent Claim as defined by the Plan; or (c) his or her right to assert or sue under any other cause of action against the Plan. The Plan may, at its discretion, pay benefits directly to a Provider, provided, however such payment does not give rise to the Health Provider having any rights under the Plan.

Appealing a Denied Medical Benefits Claim to the Board of Trustees

If Your claim for Medical Benefits is denied, You may appeal the denial decision to the Board of Trustees. If the benefit denial decision is subject to the utilization review process, You may use that process first. If this appeal process results in an adverse appeal determination based on a medical judgment or rescission of coverage, You may further elect to have the adverse appeal determination be reviewed by an External Third-Party Review.

Appeal Procedures

If a Medical Benefits claim is denied, You have a right to appeal to the Board of Trustees an adverse benefit determination under these claims procedures. These appeal procedures provide You with a reasonable opportunity for a full and fair review of an adverse benefit determination. (An "adverse benefit determination" is described at page 53.) The Board of Trustees will follow these procedures when deciding an appeal:

- Except for Urgent Care Claims discussed below, You must file an appeal within one hundred eighty (180) days following receipt of a notice of an adverse benefit determination ("the eighty (180)-day appeal period"). Your failure to comply with this important deadline may cause You to forfeit any right to any further review under these claims procedures or in a court of law.

    - If utilization review is used, the Claims Administrator's docket of Your request for utilization review establishes the date when the appeal process is initiated (the "request for review"). This written or oral request for utilization review must be made within the eighty (180)-day appeal period. If the utilization review results in an adverse determination, You must bring Your claims appeal in writing to the Board of Trustees by the later of: (i) the end of the eighty (180)-day appeal period, or (ii) within three (3) business days after the adverse utilization review decision.

    - If utilization review is not used, the adverse benefit decision must be appealed to the Board of Trustees in writing within the eighty (180)-day appeal period. The date the written appeal is postmarked or sent electronically establishes the date when the appeal is initiated (the "request for review").

- You will have the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.

- You may authorize a representative to act on Your behalf on appeal (see page 80).

- The Board of Trustees will give no deference to the initial benefit decision or the utilization review decision.

- The Board of Trustees will take into account all comments, documents, records, and other information You submitted relating to the claim, without regard to whether such information was submitted or considered in the initial benefit decision or the utilization review decision.

- The Board of Trustees will, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, consult with a health care professional with the appropriate training and experience who is neither the same individual who was consulted regarding the initial benefit decision nor any utilization review nor subordinates of such persons.

- The Board of Trustees will provide You, upon request, the names of any medical or vocational experts whose advice was obtained in connection with the initial benefit decision or utilization review decision, even if the Claims Administrator did not rely upon their advice.

- The Claims Administrator will provide You, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to Your claim; any internal rule, guideline, protocol or other similar criterion relied upon in making the initial benefit decision; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to Your medical circumstances.

Time for Deciding Non-Urgent Care Appeals

The timeframes for the Board of Trustees rendering a non-urgent care claim appeal decision depend on the type of claim as follows:

- Pre-Service claim appeals will be decided within thirty (30) days following the request for review.
- Post-Service claim appeals will be decided within sixty (60) days following the request for review.
- Concurrent claim appeals will be decided within the timeframes of the Pre-, Post- or Urgent Care claims, depending on which category of claim the concurrent claims falls under.

Filing Urgent Care Appeals

An Urgent Care appeal may be submitted to Wilson-McShane Corporation, the Claims Administrator by telephone at 952-851-5949 or toll-free at 800-535-6373. The Claims Administrator will transmit all necessary information, including the Claims Administrator's determination on review, by telephone, fax, or other available similar methods within seventy-two (72) hours after receipt of the initial request for review. If the initial request for review was under the utilization review procedure, the seventy-two (72)-hour review period starts when the request for utilization review is made.

Consideration of Record

Your voluntary appeal will be considered by the Board of Trustees, who are independent and not subordinate to those persons who rendered the decision to deny Your claims for benefits. The Board of Trustees will consider Your submission on appeal and data provided to it by Your medical Providers or the various claims processors.

A concise written notice of the decision and all key findings will be given to You within forty-five (45) days after Your written notice of appeal is received.

Written reconsiderations include the receipt of correspondence, explanation or other information from You, staff persons, administrators, Providers, or other persons as deemed necessary by the person or persons conducting the appeal for the fair appraisal and resolution of the appeal.

Notification of Appeal Decision

The Plan Administrator will provide You with written notice of the Board of Trustees' appeal decision that includes:

- A statement that You are entitled to receive, at no cost upon request, reasonable access to copies of all documents, records, and other information relevant to the claim.
- A statement that You and the Plan may have other voluntary alternative dispute resolution options, such as mediation.
- A statement that You may have the right to have an external, third-party review of Your denied appeal by an independent review organization (IRO).

- A statement that You have a right to bring a civil action under ERISA §502(a) following the denial of Your claim;
    - The specific reason(s) for the determination;
    - Reference to the Plan provision(s) on which the determination was based;
    - If Your claim is denied based on:
        - Any rule, guideline, protocol, or similar criteria, a statement that a copy of the information is available to You at no cost upon request; or
        - Medical Necessity, Experimental treatment, or similar exclusion or limit, a statement that a copy of the scientific or clinical judgment is available to You at no cost upon request.
    - We will provide You the denial code.

The decision of the Board of Trustees is to be accorded deference in any court or administrative proceeding. The Board of Trustees' decision is subject to the arbitrary and capricious standard of review.

These claims procedures must be exhausted before any legal action is commenced.

External Third-Party Review of an Adverse Appeal Decision

If the Board of Trustees denies Your appeal, You may further elect to have the adverse appeal determination be reviewed by an External Third-Party Review.

Standard External Review of Non-Urgent Claim

You may file a request for an external review within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination.

- Within five (5) business days following the date of receipt of the external review request, the Claims Administrator will complete a preliminary review of the request to determine whether:
  - You are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
  - the adverse benefit determination or the final adverse benefit determination is not based on the fact that You were not eligible under the Plan;
  - You have exhausted the Plan's internal appeal process (unless exhaustion is not required); and
  - You have provided all the information and forms required to process an external review.
- Within one (1) business day after completion of the preliminary review, the Claims Administrator will notify You in writing regarding whether Your claim is eligible for external review. To be eligible for external review, the adverse appeal decision must be based upon a medical judgment or it must involve a rescission of coverage. If Your request was not complete, the notice will describe information or materials needed to complete request. You will have until the end of the four (4)-month period You had to file a request for an external review or forty-eight (48) hours (whichever is later) to complete Your request. If Your request is complete but not eligible for external review, the notice will include the reasons Your request was ineligible and contact information for the Employee Benefits Security Administration.
- If the request is complete and eligible for external review, the Claims Administrator will assign an accredited independent review organization (IRO) to conduct the external review.
  - The IRO will utilize legal experts where appropriate to make coverage determinations under the Plan and will notify You in writing of the request's eligibility and acceptance for external review. You may submit additional information in writing to the IRO within ten (10) business days that the IRO must consider when conducting the external review.
  - The Claims Administrator will provide documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO.
  - The IRO will review all the information and documents timely received and is not bound by the Claims Administrator's prior determination. The IRO may 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 Claims Administrator, You, or Your treating Provider;
    - The terms of the Plan;
    - Evidence-based practice guidelines;
    - Any applicable clinical review criteria developed and used by the Claims Administrator; and

- The opinion of the IRO's clinical reviewer or reviewers after considering information noted above as appropriate.

- The IRO will provide written notice of the final external review decision within forty-five (45) days after the IRO receives the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision.

Expedited External Review

- You may request an expedited external review when You receive:

  - An adverse benefit determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function and You have filed a request for an expedited internal appeal; or

  - A final internal adverse benefit determination, if You have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which You received emergency Services, but have not been discharged from a Facility.

- Immediately upon receipt of the request for expedited external review, the Claims Administrator will determine whether the request meets the reviewability requirements noted above for standard external review and will notify You of its eligibility determination.

- When the Claims Administrator determines that Your request is eligible for external review an IRO will be assigned. The Claims Administrator will provide all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO by any available expeditious method.

- The IRO must consider the information or documents provided and is not bound by the Claims Administrator’s prior determination. The IRO will provide notice of the final external review decision as expeditiously as Your medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the IRO’s notice is not in writing, the IRO must provide written confirmation of the decision within forty-eight (48) hours to the claimant and the Plan.

Dental Care Benefits

The Plan provides dental care benefits using the Delta Dental Plan of Minnesota network.

How the Plan Works

There are three levels of dental benefits. You receive the highest level when You use Delta Dental PPO (network) Providers, the next highest level when You use Delta Dental Premier (participating) Providers, and the lowest level when You use non-participating Providers. The Benefits from the PPO and Premier Providers is:

Dental Care Benefits	**Delta Dental PPO Providers**	**Delta Dental Premier Providers**
Annual Maximum Benefit Per Person	$1,200	$1,200
Orthodontics Lifetime Maximum (for Children age 8-18)	$1,500	$1,500
Diagnostic and Preventive Services	100%	100%
Basic Services (fillings)	100%	80%
Endodontics (root canal)	100%	80%
Periodontics (gums)	100%	80%
Oral Surgery	100%	80%
Major Restorative Services (crowns)	100%	80%
Prosthetics	80%	80%
Prosthetic Repairs	80%	80%
Orthodontics	80%	80%

Network and participating Providers will submit claims for You. For non-participating Providers, You will have to pay the Provider and submit a claim Yourself for reimbursement. See *How to File Claims For Benefits Other Than Medical Benefits* on page 76 for details.

There is no Deductible for dental care benefits so the Plan begins paying benefits from the first dollar of covered expenses. The Plan pays up to the annual maximum for each person for most procedures, excluding preventive care for Children age eighteen (18) or under. Orthodontia is available for Children age eighteen (18) and under up to a lifetime maximum of One Thousand Five Hundred Dollars ($1,500).

You should obtain **prior approval** for all care Dental Services, except for Preventive Care or Basic Services. That is, You should obtain prior utilization review and approval for Basic Endodontic Services, Periodontics, Oral Surgery, Complex or Major Restorative Services, Prosthetic Services and Orthodontics.

Covered Expenses

The level of payment for a procedure depends on the procedure category and any specific limitations. A brief description of procedure categories follows. Exclusions for dental care benefits are listed on page 59.

Preventive Care

Oral Evaluations

The Plan covers any type of evaluation, including specialist exam, as needed.

Radiographs (X-rays)

- *Bitewings* – One series of bitewings per twelve (12)-month period.
- *Full Mouth (Complete Series) or Panoramic* – Once per thirty-six (36)-month period.
- *Periapical(s)* – single X-rays.

- *Occlusal* – One series per twelve (12)-month period.

Dental Cleaning

- *Prophylaxis*, a procedure to remove plaque, tartar (calculus), and stain from teeth is covered once in a six (6)-month period.
- *Periodontal Maintenance*, a procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment is covered once in a three (3)-month period.
- *Fluoride Treatment* (Topical application of fluoride) – Once per twelve (12)-month period.
- *Oral Hygiene Instructions*, including tooth-brushing techniques, flossing and use of oral hygiene aids are covered once in a lifetime.
- *Space Maintainers* – Once in a lifetime for eligible dependent Children through the age of 16 for extracted primary posterior (back) teeth. Repair or replacement of lost/broken appliances is not covered.

Basic Dental Care Services

- *Emergency Treatment* – Emergency (palliative) treatment for the temporary relief of pain or infection.
- *Amalgam (silver) Restorations* – Treatment to restore decayed or fractured permanent or primary teeth; limited to one per tooth surface in a twelve (12)-month period.
- *Composite (white) Resin Restorations:* Limited to one per tooth surface in a twelve (12)-month period.
  - *Anterior (front) Teeth* – Treatment to restore decayed or fractured permanent or primary anterior teeth.
  - *Posterior (back) Teeth* – This service is not covered under Basic Services. Refer to the Complex or Major Restorative Services section of Your benefits.
- *Restorative cast post and core build-up, including pins and posts* - See benefit coverage description under Complex or Major Restorative Services.
- *Pre-fabricated or Stainless Steel Crown* - Covered once per twenty-four (24)-month period for eligible dependent Children through the age of eighteen (18).
- *Sealants* - Covered once per lifetime for permanent first and second molars of eligible dependent Children through the age of fifteen (15).

Adjunctive General Services

- *Intravenous (IV) Conscious Sedation and IV Sedation* when performed in conjunction with eligible complex surgical service.

See Exclusions starting at page 59.

Basic Endodontic Services (Nerve or Pulp Treatment)

- *Endodontic Therapy on Primary Teeth* – Pulpal Therapy and Therapeutic Pulpotomy
- *Endodontic Therapy on Permanent Teeth* – Root Canal Therapy, Apicoectomy, and Root Amputation on posterior (back) teeth
- *Complex or other Endodontic Services* – Apexification (for dependent Children through the age of 16), Retrograde filling, and Hemisection (including root removal).

See Exclusions starting at pages 59-60, including 8, 18, 19, 20, 31, 32, 33, 34, and 35.

Periodontics (Gum & Bone Treatment)

- *Basic Non-Surgical Periodontal Care* – Treatment for diseases for the gingival (gums) and bone supporting the teeth.
  - *Periodontal* scaling & root planing – Covered once per twenty-four (24) months.
  - Full mouth debridement – Covered once per lifetime.
- *Complex Surgical Periodontal Care* – Limited to one complex surgical periodontal service per thirty-six (36)-month period for a single tooth or multiple teeth in the same quadrant. Surgical treatment for diseases for the gingival (gums) and bone supporting the teeth, including:
  - Gingivectomy/gingivoplasty
  - Gingival flap
  - Mucogingival surgery
  - Bone replacement graft
  - Free soft tissue graft
  - Soft tissue allograft
  - Combined connective tissue and double pedicle graft
  - Gingival curettage
  - Apically positioned flap
  - Osseous Surgery
  - Pedicle soft tissue graft
  - Subepithelial connective tissue graft
  - Distal/proximal wedge

See Exclusions starting at pages 59 and 60.

Oral Surgery (Tooth, Tissue, or Bone Removal)

- *Basic Extractions* – Removal of coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth, extraction of erupted tooth or exposed root.
- *Complex Surgical Extractions* – Surgical removal of erupted tooth, impacted tooth, or residual tooth roots.
- *Other Complex Surgical Procedures:*
  - Oroantral fistula closure
  - Tooth reimplantation – accidentally evulsed or displaced tooth
  - Transseptal fiberotomy
  - Vestibuloplasty
  - Removal of exostosis
  - Incision & drainage of abscess
  - Removal or nonodontogenic or odontogenic cyst or tumor
  - Biopsy of oral tissue
  - Surgical exposure of impacted or unerupted tooth to aid eruption
  - Alveoloplasty
  - Excision of lesion or tumor
  - Partial ostectomy
  - Frenulectomy (frenectomy or frenotomy)
- *Temporomandibular Joint Disorder (TMJ)* – Dental treatment that is considered surgical and nonsurgical treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder, including splints, is subject to the coordination of benefits. A Pre-treatment Estimate of Benefits is recommended. The claim must first be submitted as a medical claim. Once You receive Your Explanation of Benefits from the medical plan, You may submit a dental claim for any unpaid costs.

See Exclusions starting at pages 59 and 60.

Complex or Major Restorative Services

These Services performed to restore lost tooth structure because of decay or fracture are covered:

- *Posterior (back) teeth composite (white) resin restorations* – If the posterior tooth requires a restoration due to decay or fracture and no other posterior composite resin restoration for the same or additional tooth surface(s) was performed within the last twenty-four (24) months.
- *Gold foil restorations* – Receive an amalgam (silver filling) benefit equal to the same number of surfaces and allowances**.** The patient must pay the difference in cost between the Plan's Payment Obligation for the covered benefit and the dentist has submitted fee for the optional treatment, plus any coinsurance for the covered benefit.
- *Inlays* **–** Benefit will equal an amalgam (silver) restoration for the same number of surfaces.
- *Onlays* **–** Once every five-year period per tooth.
- *Permanent crowns* **–** Once every five-year period per tooth.
- *Implant crowns* – See Prosthetic Services.
- *Crown Repair* – Once every twelve (12)-month period per tooth.
- *Restorative cast post and core build-up,* including one post per tooth and one pin per surface, once every five-year period when done in conjunction with covered Services.
- *Canal prep & fitting of preformed dowel & post.*

See Exclusions starting at pages 59 and 60.

Prosthetic Services (Dentures, Partials, and Bridges)

- *Reline, rebase, repairs, replacement of broken artificial teeth, replacement of broken clasp(s)* – For permanent prosthetic appliances at least six (6) months following initial placement of the prosthetic appliance.
- *Adjustments* **–** Once per twelve (12)-month period for permanent appliances following six (6) months after initial placement.
- *Removable prosthetic Services (dentures and partials)* **–** Once every five-year period for covered persons age 16 or older, for the replacement of extracted (removed) permanent teeth, if five years have elapsed since the last benefited removable prosthetic appliance (denture or partial) and the existing appliance needs replacement because it cannot be repaired or adjusted.
- *Fixed prosthetic Services (bridge)* **–** Once every five-year period, for covered persons age 16 or older; for the replacement of extracted (removed) permanent teeth, if none of the individual units of the bridge has been benefited previously as a crown or cast restoration in the last five years, and if five years have elapsed since the last benefited removable prosthetic appliance (bridge) and the existing appliance needs replacement because it cannot be repaired or adjusted.
- *Implant supported fixed and removable prosthetic (crowns, bridges, partials and dentures)* – A restoration that is retained, supported and stabilized by an implant. Implants and related Services are NOT covered.
- *Restorative cast post and core build-up, including pins and posts* **–** Once every five-year period when done in conjunction with covered fixed prosthetic Services.
- *Dental implants, implant abutments, bone grafts and other related services.*

See Exclusions starting at pages 59 and 60.

Orthodontics

Orthodontia treatment for Dependents through age eighteen (18) is covered, if necessary for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies with a lifetime maximum of One Thousand Five Hundred Dollars ($1,500).

Because orthodontic treatment normally occurs over a long period, benefit payments are made over the course of treatment. The Dependent must have continuous eligibility under the Plan in order to receive ongoing orthodontic benefit payments. Benefit payments are made in equal amounts: (1) when treatment begins (appliances are installed); and (2) at six (6)-month intervals thereafter, until treatment is completed.

Before treatment begins, the treating dentist should submit a Pre-treatment Estimate. An Estimate of Benefits form will be sent to You and Your dentist indicating the estimated Plan payment amount. This form serves as a claim form when treatment begins. When treatment begins, the dentist should submit the Estimate of Benefit form with the date of placement and his/her signature. After benefit and eligibility verification by the Plan, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be issued to You and Your dentist. This again will serve as the claim form to be submitted six (6) months from the date of appliance placement.

Exclusions to Dental Care Benefits

Coverage is NOT provided for:

1. Dental Services which a Covered Person would be entitled to receive for a nominal charge or without charge if this Plan were not in force under any Workers' Compensation Law, Federal Medicare program, or Federal Veterans' Administration program. However, if a Covered Person receives a bill or direct charge for dental Services under any governmental program, then this exclusion will not apply. Pursuant to Minnesota Statute Section 62A.045, benefits under this Plan will not be reduced or denied because dental Services are rendered to a subscriber or Dependent who is eligible for or receiving Medical Assistance.
2. Dental Services or health care Services not specifically covered under the Group Dental Plan (including any Hospital charges, prescription drug charges and dental Services or supplies that are medical in nature).
3. New, Experimental, or Investigational dental techniques or Services may be denied until there is, to the satisfaction of the Plan, an established scientific basis for recommendation.
4. Dental Services performed for Cosmetic purposes.
5. Dental Services completed prior to the date the patient became eligible for coverage.
6. Services of anesthesiologists. (Note: In certain cases, there may be coverage under the Medical Plan.)
7. Anesthesia Services, except by a Dentist or by an employee of the Dentist when the service is performed in his or her office and by a dentist or an employee of the dentist who is certified in their profession to provide anesthesia Services. (Note: In certain cases, anesthesia Services may be covered under the Medical Plan.)
8. Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care, regardless of the method of administration. NOTE: Intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with covered complex surgical Services.
9. Dental Services performed other than by a licensed dentist, licensed Physician, his or her employees.
10. Dental Services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
11. Any artificial material implanted or grafted onto bone or soft tissue, including implant procedures and associated fixtures, sinus augmentation in preparation for implants, or surgical removal of implants.
12. Services or supplies that have the primary purpose of improving the appearance of Your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
13. Orthodontic treatment Services, unless specified in this Dental Benefit Plan Summary as a covered dental service benefit.

14. Case presentations, office visits and consultations.
15. Incomplete, interim or temporary Services.
16. Corrections of congenital conditions during the first twenty-four (24) months after birth
17. Athletic mouth guards, enamel microabraision and odontoplasty.
18. Coverage for root canal therapy on the same tooth is limited to once per lifetime.
19. Procedures designed to enable prosthetic or restorative Services to be performed such as a crown lengthening.
20. Bacteriologic tests.
21. Cytology sample collection.
22. Separate Services billed when they are an inherent component of a Dental Service where the benefit is reimbursed at an Allowed Amount.
23. Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).
24. Interim or temporary removable or fixed prosthetic appliances (dentures, partials or bridges).
25. The replacement of an existing partial denture with a bridge.
26. Additional, Elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
27. Provisional splinting, temporary procedures or interim stabilization.
28. Placement or removal of sedative filling, base or liner used under a restoration.
29. Services or supplies that are medical in nature, including dental oral surgery Services performed in a Hospital.
30. Occlusal procedures including occlusal guard and adjustments.
31. Removal of pulpal debridement, pulp cap, post, pins, resorbable or non-resorbable filling materials in the canals (root).
32. Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
33. Intentional reimplantation and associated procedures.
34. The controlled release of therapeutic agents, biologic materials or chemotherapy used to aid in soft tissue and osseous tissue regeneration.
35. Bone and/or tissue grafts performed in preparation for dental implants.
36. Surgical repositioning of teeth.
37. CT Scans ordered by dentist for diagnosis of dental condition other than fracture of facial bone. Any claim must first be submitted to the patient's medical plan.

Vision Care Service Plan

St. Paul Electrical Workers Health Plan has a vision plan administered by Vision Service Plan ("VSP"). Call a VSP Doctor, identify Yourself as a VSP member, schedule an appointment and VSP takes care of all the rest. There is no need for ID cards; there are no claim forms to be filed. To locate a VSP Provider call 1-800-877-7195 or go online at www.vsp.com. Enroll as a member in the "Choice Plan" at www.VSP.com.

In-Network Benefits

A Benefits summary is available at www.vsp.com. Currently, the benefits each calendar year are:

Vision Care Benefit	In-Network Coverage	Out-of-Network Coverage
Vision Service Plan (January 1 – December 31)		
VSP Well Vision Exam (one per calendar year)	100% No Co-pay, even if there is retinal screening	$200 allowance every calendar year. This can be used for exam, lenses, frame and contact lenses combined.
Prescription Glasses • Lenses (one per calendar year) o Single vision, lined bifocal and lined trifocal o Polycarbonate lenses for all	100%	$200 allowance every calendar year. This can be used for exam, lenses, frame and contact lenses combined.
• Lens Enhancement (every calendar year) o Standard progressive lenses o Premium progressive lenses o Custom progressive lenses o Average savings of 20-25% on other lens enhancements	• $55 Co-pay • $95-$105 Co-pay • $150-$175 Co-pay	
• Frame (every calendar year)	• $150 allowance for frame of Your choice • $170 allowance for featured frame brands • 20% off the amount over Your allowance • $80 Costco© frame allowance	$200 allowance every calendar year. This can be used for exam, lenses, frame and contact lenses combined.
• Contact Lenses (in lieu of prescription glasses) (every calendar year)	• $150 allowance for contacts and contact lens exam (fitting and evaluation); • 15% savings on contact lens exam (fitting and evaluation).	$200 allowance every calendar year. This can be used for exam, lenses, frame and contact lenses combined.
• Corrective Laser/Lasik Eye Surgery (in lieu of that year's prescription glasses or contacts)(once per lifetime)	• 80% up to $1,500 Plan benefit for all fees related to evaluation and surgery	60% up to $1,500 Plan benefit for all fees related to evaluation and surgery

Vision Care Benefit	In-Network Coverage	Out-of-Network Coverage
Additional Savings	• Addition glasses and Sunglasses get an extra $20 on featured frame brands plus 20% savings on certain brands. • Laser vision correction is on average 15% off the regular price or 5% off the promotional price. Discounts is only available at certain facilities.	

NOTE:

- You are only eligible for benefits under the Vision Service Plan one time per calendar year per Participant using either a Network or a Non-Network Provider. Benefits may not be split between Network and Non-Network. For example, You may not get an eye exam through VSP and materials at a Non-Network Provider.

Out-Of-Network Benefits

A total allowance up to Two Hundred ($200) is available every calendar year. This allowance can be used for exam, lenses, frames and contact lenses. For any Out-of-Network Services a "paper" claim must be filed with Vision Service Plan. Contact VSP at 1-800-877-7195 for claim forms.

Hearing Aid Benefits

The Plan provides a Hearing Aid Benefit funded directly through the Trust.

Hearing Aid Benefits

Hearing Aid Benefits reimburse You and Your covered Dependents for Medically Necessary hearing aids up to Two Thousand Five Hundred Dollars ($2,500) per person in the five-year period, beginning November 1, 2015 through October 31, 2020.

Physician Neck and Spine Chronic Spine Pain Program

The Trustees strongly recommend that Participants contemplating spine surgery learn more from Physician Neck & Back Clinic (PNBC) Chronic Spine Pain Program. PNBC has a very high success rate in spinal care without surgical intervention.

Participants enrolling in the PNBC Chronic Spine Pain Program and successfully completing the treatment program will receive one hundred percent (100%) coverage of all charges for the program plus one hundred percent (100%) reimbursement of the cost of PNBC-approved maintenance equipment after completing the program. Participants who enroll in the PNBC Chronic Spine Pain Program who do not complete the program without PNBC's approval to discontinue the program will be solely responsible for the costs of the program.

Supplemental Retiree Medical Coverage

The Plan provides Supplemental Medicare Coverage for Retirees. You will be eligible for this coverage when You retire if You:

- Are eligible for Medicare;
- Were a Participant in the Plan at the time of Your retirement;
- Had a minimum of sixty (60) months of participation (as long as the months are consecutive or the period in Covered Employment after an interruption is greater than the interruption, if any) in the Plan immediately preceding Early Retirement;
- Are enrolled in Medicare Parts A and B; and
- Make payments to the Plan for coverage. (You may use Your Eligibility Bank or SUB/ME account balance to pay for this coverage.)

Your Spouse may also be eligible for coverage, if eligible for Medicare, and if payments for coverage are made. (In the event Your Spouse is not yet eligible for Medicare, You may elect to continue coverage as a Retiree until Your Spouse qualifies for Supplemental Medicare coverage.)

Your Spouse, who at the time of Your death was covered by the Plan, may continue coverage uninterrupted until he or she becomes eligible for Medicare, provided he or she pays for the coverage through self-payments (see page 12 and 13). Your Spouse may use Your Eligibility Bank and SUB/ME balances to pay for this coverage.

The self-pay cost will be determined by the Trustees and may be adjusted from time to time.

Coordination of Benefits

Benefits Subject to this Provision

Medical expense benefits under the Medical Plan, the Dental Care Plan or the Vision Care Plan are subject to this provision.

Effect on Benefits

Coordination of Benefits (COB) means that the benefits provided by this Plan will be coordinated with the benefits provided by any other Plans covering the Participant for whom claim is made. If this Plan is a Secondary Plan, the benefits payable under this Plan may be reduced, so that a Participant's total payment from all Plans will not exceed one hundred percent (100%) of his or her total Covered Charges.

"Primary Plan" means the Plan which pays benefits or provides Services first under the Order of Benefit Determination Rules below. The Primary Plan does not reduce its benefits because of duplicative coverage.

"Secondary Plan" means any Plan which provides coverage for the Participant or Beneficiary for whom claim is made and which is not a Primary Plan.

The Co-pays, Deductibles, and Co-insurance payments made by a Participant will be coordinated to one hundred percent (100%), in the event both the Employee Participant and Spouse Participant are covered by the Health and Welfare Fund.

Plans Considered for COB

A "Plan" is any arrangement which provides coverage for a Participant or Beneficiary for whom claim is made. A "Plan" does not include individual policies other than individual No-Fault auto insurance, by whatever name called.

COB applies to the following Plans:

- Group insurance.
- Other arrangements, whether insured or uninsured, covering Participants in a group,
- Plans designed to pay a fixed dollar benefit per day while the Participant or Beneficiary is Hospital confined, but which, at the time of claim, allow the Participant to elect an alternate benefit.
- Plans designed to pay a fixed dollar benefit per day while the Participant is Hospital confined.
- Plans of other Hospital medical service organizations on a group basis.
- Group practice plans.
- Group prepayment plans.
- Coverage under Federal Government plans or programs, including Medicare subject to specific provisions in this Plan related to coordination with Medicare.
- Coverage required or provided by law. COB will not apply to state programs which provide benefits for Participants unable to pay for their care.
- Group auto insurance.
- Individual no-fault auto insurance, by whatever name called.

NOTE: This Plan is always a Secondary Plan to benefits provided under any mandatory No-Fault Auto Insurance Act in the state in which the Participant resides.

Order of Benefit Determination

- Any Plan which does not have a COB or similar provision will pay its benefits first.
- All Plans which have a COB or similar provision will pay in the order determined by the following rules:
    - A Plan which covers a Participant as an Employee will be considered before a Plan which covers the Participant as a Dependent.
    - A Plan which covers a Participant as an active employee, or as the Dependent of an active employee, will be considered before a Plan which covers the Participant as a laid-off or retired employee. NOTE: If a Plan which is being considered for COB does have a provision regarding laid-off or retired employees, then this rule will not apply.
    - For dependent Children, the Plan which pays first is determined by the parents' birthdays. The Plan which covers the parent whose month and day of birth occurs earliest in the Calendar Year will be considered first. NOTE: If a Plan which is being considered for COB does not have a birthday rule for dependent Children, then the COB rules in the other Plan will be used and this rule will not apply.

NOTE: The following exception applies to the rule for dependent Children above. When the natural parents of a dependent Child are divorced or legally separated or never married, the following rules apply.

- If the parent with custody of the Child has not remarried, the benefits of a Plan which covers the Child as a Dependent of the parent with custody of the Child will be considered first.
- If the parent with custody of the Child has remarried, the benefits of the Plan which covers the Child as a Dependent of the parent with custody of the Child will be considered before the benefits of a Plan which covers the Child as a Dependent of his or her step-parent; and the benefits of a Plan which covers the Child as Dependent of the parent without custody of the Child will be considered last.
- Except that, if there is a court decree which establishes financial responsibility for the medical, dental or other health care expenses of the Child, the first two bullets above will not apply, and the Plan which covers the parent with such financial responsibility will be considered before the benefits of any other Plan which covers the Child as a Dependent.
- If the above rules do not establish an Order of Benefit Determination (such as when two Plans cover the Participant as an Employee/Participant or in certain instances where the Dependent is an Adult Child who is not in the custody of the parent), the Plan which has covered the Participant for the longest continuous period of time will be considered first.

Operation of COB

In order to make this COB provision work properly:

- Upon request, the Participant is required to furnish to the Fund complete information concerning all Plans which cover the Participant for whom claim is made.
- As permitted by law, the Fund may, without the Participant's consent:
    - Obtain information from all Plans which may cover the Participant; and
    - Release to such other Plans any information it has with respect to any Participant.

- If payments which should have been made by the Fund have been made under any other Plans, the Fund may reimburse such other Plans to the extent necessary to make this provision work. Any such payment will be a benefit paid under this Plan.

- If the Fund has paid benefits which result in payment in excess of the amount necessary under this Plan to make this provision work, the Fund has the right to recover such excess payment from:

  - Any person;

  - Any other insurance company;

  - By offsetting the excess overpayment against future benefit payments made on Participant or Participant Dependent's behalf; or

  - Any other organization to or for or with respect to whom such payments were made.

Coordination of Benefits with Medicare

If You are eligible for Medicare and You enroll in Medicare Advantage, You must use Network Providers and comply with the managed care Provider's requirements. If You do not, benefits paid under this Plan will be limited to the amount that would have been paid by Medicare had You used a Network Provider and/or complied with the managed care Provider's requirements.

The provisions of this section apply to some but not all persons who are eligible for Medicare Parts A and B. They apply in situations where the federal Secondary Medicare Payor Program allows Medicare to be the primary payor of a person's health care claims. For help in determining whether or not Medicare is primary in Your situation, contact the Plan Administrator.

Medicare is secondary payor for You an/or Your Dependent if: (1) You and/or Your Dependents have coverage under this Plan due to Your active employment; and (2) You and/or You Dependents are covered by Medicare because they have either reached age 65 or because of disability. The Medicare secondary payor rules change from time to time and the most recent rule will be applied. This rule is current as of the date of this SPD.

Benefits paid under this Plan will be reduced by the amount of any benefits or compensation to which the Participant is entitled under Medicare. A Participant is deemed to be entitled to all Medicare Benefits for which he or she is or has been eligible, and the benefits under this Plan will be reduced whether or not the Participant has received or made application for such Medicare benefits.

The provisions described in this section will apply to the maximum extent permitted by federal law. The Plan will not reduce benefits in situations where federal law requires that the Plan determine its benefits without regard to a covered person's benefits under Medicare.

If You are retired and eligible for Medicare, Supplemental Retiree Medicare coverage, an insured plan, may be purchased which coordinates differently with Medicare.

Coordination of Benefits with Automobile Insurance

Benefits payable by this Plan are not in lieu of those that would be payable under no-fault automobile insurance or other statutorily required automobile insurance and does not affect any legal requirement that you maintain the minimum insurance coverage within the jurisdiction in which you reside.

For any medical expenses arising from the maintenance or use of a motor vehicle, no-fault automobile insurance will calculate and pay its benefits first and this Plan will calculate and pay benefits second. If no-fault coverage is not required within the jurisdiction in which you reside, any medical payments coverage or personal injury protection insurance will 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 one hundred (100%) of the expenses incurred.

Benefits that would be payable by no-fault automobile insurance will not be paid by this Plan merely because you failed to file a claim for no-fault benefits. Likewise, benefits will not be paid by this Plan until any medical payments coverage or personal injury protection coverage is exhausted. If you failed to maintain the legally required no-fault or other legally required coverage within the jurisdiction in which you reside, Plan benefits will not be payable for amounts which the legally required amount of automobile insurance otherwise would have paid.

In the event that the no-fault automobile insurer discontinues payments prior to the statutory minimum or denies coverage, if you were injured in an automobile accident which is, or should be, covered by no-fault automobile insurance, you must arbitrate any notice of discontinuance or denial of coverage by no-fault automobile insurance or benefits related to the accident will not be payable under this Plan.

Information Gathering

To implement the provisions in this coordination of benefits section, the Trustees may release or obtain any information necessary to or from any insurance company, organization, or person without Your consent or release, in accordance with the Plan's Privacy Policy (see following section). Any person claiming benefits under this Plan must provide any information necessary to implement the coordination of benefits provisions or to determine their applicability.

Privacy Policy

The Plan is required to protect the confidentiality of Your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services.

Protected Health Information (PHI)

All individually identifiable health information transmitted or maintained by the Plan that relates to Your past, present, or future health, treatment, or payment for health care Services.

You may find a complete description of Your rights under HIPAA in the Plan's Privacy Notice that describes the Plan's privacy policies and procedures and outlines Your rights under the privacy rules and regulations.

Your rights under HIPAA include the right to:

- Receive confidential communications of Your protected health information, as applicable;
- See and copy Your health information;
- Receive an accounting of certain disclosures of Your health information;
- Amend Your health information under certain circumstances; and
- File a complaint with the Plan or with the Secretary of Health and Human Services if You believe Your rights under HIPAA have been violated.

A copy of the Privacy Notice is attached to this SPD as Exhibit B. If You need another copy of the policy or require additional information, please contact the Plan's Privacy Officer at the Fund Office.

Disability Benefit Plan

Only Participants (bargaining and Non-Bargaining Unit Employees) on whose behalf contributions are made to the Plan by the employer specifically for the Disability Benefit Plan are eligible for disability benefits.

General Provisions

The Trustees may require a second Doctor's opinion before commencing benefit payments for Your Temporary Total Disability or Total and Permanent Disability. Benefits consist of income replacement benefits and free medical coverage.

The second Doctor will be selected by the Board of Trustees. If the first two Doctors do not agree, the opinion of a third Doctor mutually agreeable to the first two Doctors will be required. If the second and third Doctors determine that You are not disabled, no benefits will be paid.

The Plan will pay for any required second or third opinions.

Disability Benefits	**Employee Only**
Temporary Total Disability Income Replacement Benefit • Maximum Weekly Benefit • Maximum Duration Benefits Begin	 $740 up to 26 weeks On first day of Injury or eighth day for an Illness or first day if hospitalization or with surgery
Maternity Leave Income Replacement Benefit • Weekly Benefit • Duration of Benefit	 $750 8 paid weeks for natural childbirth starting on date of delivery 12 paid weeks for Caesarean Section starting on the date of delivery
Own Occupation Temporary Disability Income Replacement Benefit • Weekly Benefit • Maximum Duration	Half the benefit received for Temporary Total Disability twenty-four (24) months
Permanent Total Disability Income Replacement Benefit • Monthly Benefit • Maximum Total Benefit	 $325 $20,500
Medical Coverage During Temporary Disability	Free for up to thirty (30) months
Medical Coverage During Permanent Disability	Free

Weekly Benefit for Temporary Total Disability of the Participant

Temporary Total Disability means that You are unable to engage in the usual and customary duties of Your own occupation due to bodily Injury or Illness. The Trustees will pay a weekly benefit if You are ill or injured and qualify for Temporary Total Disability coverage.

The benefit is seven-hundred-forty dollars ($740) per week (one-hundred-forty-eight dollars ($148) per day).

You are eligible for the benefit, up to a maximum of twenty-six (26) weeks per period of disability, if employer contributions or disability benefit payments for the Disability Benefit Plan are made on Your behalf to the Trust Fund, and You are under the care of a Physician or Chiropractor.

If the qualifying Illness is pregnancy, there is a presumed Temporary Disability period which runs from the date of delivery. In the case of natural childbirth, the presumed period of Temporary Disability is 8 weeks from the date of delivery. In the case of childbirth by Caesarian Section, the presumed period of Temporary Disability is 12 weeks. There may be a period of Temporary Disability prior to childbirth upon providing proof of such disability with a Doctor's opinion. The presumed period of Temporary Disability may further be extended upon providing proof of such Disability with a Doctor's opinion.

Benefits are paid according to these rules:

- Due to an Acute Injury, the benefit begins with the *first (1st)* day of the disability.
- Due to an Illness, the benefit begins with the *eighth (8th)* day of the disability. The benefit is payable, however, from the first day of an Illness if You are hospitalized or undergo surgery.
- One-fifth of the weekly benefit will be paid for each day of total disability, not to exceed a maximum of five (5) days during any week of disability.
- If You begin receiving benefits, and then return to full-time active work for less than two weeks before stopping work again because of the same disability, the time spent on temporary disability will be considered one benefit period.
- If, however, the second period of disability is a result of a different Illness or Injury, and You spend at least one full day in active employment, it will be considered two separate benefit periods.
- If You work less than one full day between times of disability, it will be considered one benefit period, unless the Trustees determine that the other permanent disability requires extended coverage.
- If You are receiving other disability payments, or sick leave pay, during Your period of disability, Your weekly benefit will be reduced by the amount by which Your other disability payments exceed twice the amount of this Plan's disability benefit. If the total of Your other payments do not exceed the amount of this Plan's disability benefit there will be no reduction.
- You must file a Return-to-Work form (available at the Fund Office) no later than five (5) days after the date You returned to work. If You fail to file this form and properly notify the Plan of the date You returned to work, You will be assessed an administrative fee for processing any benefit refunds resulting from overpayment of benefits.
- No benefit will be paid if:
  - Illness or Injury begins after You are seventy (70) years old; or
  - Illness or Injury begins while You are unemployed. (If You are a bargaining unit employee and unemployed through no fault of Your own and suffer an Illness or Injury that disqualifies You from unemployment compensation, You will be eligible for temporary disability benefits.); or
  - You have not been seen and treated personally by a Physician or chiropractor; or
  - You have not submitted the proper disabling statement; or
  - A disability is caused by Chemical Dependency for which You are currently in treatment; or
  - Any provision of the Plan specifically excludes coverage of treatment for Your Illness or Injury; or
  - You have not enrolled in and complied with the disability management program as established by the Trustees; or

- You are receiving benefits under Workers' Compensation Law.

Job Related Disability

If Your period of disability is shorter than that which qualifies for Workers' Compensation, and if You are under the care of a Physician or Chiropractor, You will receive Fifty Dollars ($50) per day for up to three (3) days, as compensation for lost wages.

If You miss a day of work for treatment by a Physician or Chiropractor after the first day of a job-related Injury, You will be compensated at Your regular hourly rate, not to exceed one-fifth (1/5) of Your normal weekly disability benefits for any day or part of a day.

Own Occupation Temporary Disability of the Participant

If You exhaust the benefits under Temporary Total Disability Income Replacement Benefit and are still unable to engage in the usual and customary duties of Your own occupation because of an Injury or Illness, You may be eligible to receive Own Occupation Temporary Disability Benefits. Own Occupation Temporary Disability means You have not suffered a Total Permanent Disability, have exhausted the Temporary Disability benefits in Part A and You are still unable to engage in the usual and customary duties of Your own occupation due to bodily Injury or Illness.

The Plan will pay a weekly benefit of 50% of the benefit You were receiving under Part A when You qualify for the Own Occupation Temporary Disability. The weekly benefit payments will continue until the earlier of any of the following events:

- You are released to return to work in Your own occupation.
- The Trustees determine that You have a Total Permanent Disability.
- You have received the maximum benefit of twenty-four (24) consecutive months of Own Occupation Temporary Disability.

You must follow these rules:

- You must continue to participate in the disability management programs as established by the Trustees.
- You must file a Return-to-Work form (available at the Fund Office) no later than five days after the date You returned to work. If You fail to file this form and properly notify the Plan of the date You returned to work, You will be assessed an administrative fee for processing any benefit refunds resulting from overpayment of benefits.

If You are receiving other disability benefits or sick leave pay, during Your period of disability, Your weekly benefit will be reduced by the amount by which Your other disability payments exceed twice the amount of the Plan's disability benefit. If the total of Your other payments do not exceed the amount of this Plan's disability benefit, there will be no reduction.

You may earn up to two times Your disability benefit from a job without reduction of Your disability benefit provided the job is not in Your own occupation. Your weekly benefit will be reduced to the extent such earnings exceed twice Your disability benefit.

Permanent Total Disability Benefit for the Participant

You are eligible for Permanent Total Disability Benefits if all the following apply:

- You have a minimum of one hundred twenty (120) consecutive months of participation in this Plan immediately preceding the date of disability. However, if You are a Regular Employee and are unemployed due to a lack of work, then periods of such unemployment will count toward the one

hundred twenty (120) consecutive months, if You can provide verification that You did not leave the industry, remained properly registered and available for work, and that You did not refuse work.

- You have exhausted the benefits provided for Temporary Total Disability Income Replacement Benefits.

- You have furnished medical proof of Your permanent and total disability that is satisfactory to the Trustees.

- You have provided information from time to time about Your status, as required by the Trustees.

- The benefit amount is Three Hundred Twenty-five Dollars ($325) per month. This benefit will be paid until the earliest of the following:

  - You receive Permanent Total Disability Benefit payments from the Disability Benefit Plan totaling Twenty Thousand Five Hundred Dollars ($20,500); or

  - You are no longer permanently and totally disabled; or

  - You become eligible to receive benefits from:

    - The St. Paul Electrical Construction Pension Plan for Early Retirement if the disability occurred before July 1, 1997;

    - Any other pension plan (except the National Electrical Benefit Fund); or

    - You die.

Medical Coverage While Disabled – Regular Employees Only

If You are a Regular Employee:

- Temporary Total Disability. If You have a Temporary Total Disability, You are entitled to free medical benefits coverage (medical, dental, and vision) for up to a maximum of thirty (30) months or the earlier of: (1) being released to return to work; (2) no longer receiving short-term disability benefits under the state laws governing Workers' Compensation or from this Plan; or (3) obtaining Permanent Total Disability status.

- Permanent Total Disability. You are entitled to free medical benefits coverage (medical, dental, and vision) unless You are eligible for benefits from the Retiree Medical Funding Plan.

- This extension of free medical coverage while disabled is available *only* to Regular Employees. All other classifications of employee (non-bargaining unit or LEA) are ineligible for this extension of free medical coverage.

Employee Assistance Program

From time to time, we all deal with personal problems, both large and small. Sometimes we need help to resolve our problems.

Your Employee Assistance Program, provided through TEAM, is a confidential assessment, counseling and referral service for You and Your family to help resolve personal problems which may be affecting Your life at work and at home.

Skilled counselors are available twenty-four (24) hours a day to talk with You in confidence about Your problems. Your TEAM counselor can help You with:

- Family and marriage issues;
- Alcohol or controlled substance dependency;
- Emotional concerns;
- Legal referrals;
- Medical considerations; or
- Work-related problems.

For example, Your counselor can help You find a nursing home for Your mother, recommend a new Physician, counsel a chemically-dependent person in Your family, locate a marriage counselor for long-term counseling, or find a financial counselor to help You plan Your budget.

Although the counseling to which You are referred may not be eligible for reimbursement under the provisions of this Plan, TEAM may be able to assist in accessing the appropriate Providers of service for family, marriage, or financial counseling.

How to Use Your Employee Assistance Program

If You think You need help with a problem, dial the **confidential hotline** at **(651) 642-0182 or 800-634-7710 or www.team-mn.com**.

Some problems can be resolved with a counselor in just a few minutes over the phone. Or, You may choose to schedule a meeting with a counselor at any of TEAM's convenient locations throughout the metro area.

At the first meeting, which will last about one (1) hour, Your counselor will discuss Your problems with You and determine the type of assistance You need. More meetings with Your same counselor can be made, or, if You and the counselor decide that long-term counseling or treatment is needed, a referral to the appropriate agency will be made.

Your counselor will follow up with You to make sure that You were satisfied with the service received and that Your problem is being resolved.

The assessment, short-term counseling, and referral Services are paid for by the Plan. If You are referred for long-term counseling or treatment, You are responsible for the cost of these Services. The Plan may or may not cover some of these costs. Your counselor will consider Your particular employee benefits situation when suggesting a referral.

Life Insurance

You are eligible for coverage if You are an active, Regular Employee or Non-Bargaining Employee or an Early Retiree and a Plan Participant.

If You are laid off or terminated, You may continue life insurance coverage by paying for the premium Yourself for up to eighteen (18) months. After eighteen (18) months, You may convert this coverage into an individual policy.

If You die, Your Beneficiary will receive Ten Thousand Dollars ($10,000) in life insurance after submitting a claim with the required certified death certificate.

You may change Your Beneficiary at any time by completing and submitting a new Beneficiary card to the Fund Office. The Plan will pay the life insurance benefit as follows:

- If You named more than one Beneficiary, then equally to each Beneficiary listed.
- If You did not name a Beneficiary, then to the first surviving class in the following order of preference, Your:
  - Surviving Spouse;
  - Children, in equal shares;
  - Parents, in equal shares;
  - Siblings, in equal shares; or
  - Estate.

If Your Beneficiary is a minor or otherwise incapable of providing a valid release of payment, then payment will be made to a legal guardian or someone who has the custody and principal support of such Beneficiary.

Life insurance benefits are fully insured through:

ULLICO
8403 Colesville Road
Mail Stop #709
Silver Spring, MD 20910
202-682-6768
866-795-0680

Jury Duty Benefit

If You are a Regular Employee covered by the Plan, You are eligible for jury service benefits on the first day of employment and thereafter while employed under the provisions of the Collective Bargaining Agreement. If You are unemployed, you are eligible for jury service benefits provided You are actively seeking to be engaged in covered employment pursuant to the administrative procedures of IBEW Local Union 110 Referral Office.

You will receive reimbursement for each day served on jury duty, at the same rate of pay that You received on the last workday preceding the day on which You report to the court, less any payment received from the court. If You are an unemployed eligible Regular Employee, You will be compensated at the appropriate journeyman or apprentice rate, less any payment received from the court. In addition, You will have credited from the Plan any contributions that are required to be made to the Eligibility Bank. You will need to follow these rules, as appropriate:

- If You are employed, You must notify Your employer immediately that You have been called to jury service.

- Whether employed or unemployed, each week You must submit a statement of certification from the court showing total payment received from the court and the days You served.

- Whether employed or unemployed, You will then be reimbursed on the first payday after the form is received for wages lost as a result of such jury service less the amount You were paid by the court for jury service.

If You are employed and are released by the court for one (1) day or more during the jury service period, You will report to Your employer for assignment.

Supplemental Unemployment Benefits (SUB/ME)

The Supplemental Unemployment Benefits (SUB/ME) are described in detail at page 9 of this SPD.

How to File Claims for Benefits Other Than Medical Benefits (Dental Care, Hearing, Vision Care, Medical Eligibility Bank, SUB/ME, Disability, Life or Jury Duty)

Where to Submit Dental Care Claims

When You submit a claim for Dental Care Benefits, Wilson-McShane Corporation will determine if You are eligible for benefits and calculate the amount of benefits payable, if any. All claims will be processed promptly after complete claim information is received by Wilson-McShane Corporation. When submitting a Dental Care claim, contact Wilson-McShane Corporation at 952-851-5949 and request the appropriate claim form. Then complete the form, include any supporting documents necessary, and submit the claim to Wilson-McShane Corporation at:

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

Where to Submit a Disability, Hearing Aid, Life Insurance, Medical Eligibility Bank, SUB/ME Claims

Claims for short or long-term disability, hearing aids, life insurance, Medical Eligibility Bank, SUB/ME should be filed with the Fund Office. Forms for these claims are available by calling the Fund Office at 952-851-5949 and should be sent to:

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

For Life Insurance and AD&D claims, You or Your Beneficiary should send a certified copy of the death certificate (if applicable) with the completed claim form to the address noted above.

Where to Submit Vision Care Claims

If You use a VSP Network Provider, no claim forms need to be filed. If You use an Out-of-Network Provider, You must submit a paper claim form to VSP for reimbursement. To locate a VSP Provider or get a claim form for an Out-of-Network claim, call VSP at 1-800-877-7195 or go to their website at www.VSP.com and enroll as a member in the "Choice" plan.

Benefit Determination

You will be notified of an initial determination within the timeframes described below. If circumstances require an extension of time for making a determination on Your claim, You will be notified, in writing, that an extension is necessary. The notice will state the special circumstances and the date a determination is expected.

The deadlines differ for the different types of claims as shown in the following information:

- **Dental Benefits, Medical Eligibility Bank and SUB/ME Benefits:** All claims must be submitted within twelve (12) months of the date of the service. An initial determination will be made within thirty (30) days from receipt of Your claim. If the Plan Administrator determines that additional time is necessary to make a determination due to matters beyond the control of the Plan, You will be notified within the initial thirty (30)-day deadline that up to fifteen (15) additional days may be needed. If

additional information is needed to process Your claim, the initial period will be suspended and You will be notified of the information that is needed. You then have up to forty-five (45) days from receipt of the notice to provide the requested information. After the information is received, but no more than forty-five (45) days after the request for information is made, a determination will be made and You will be notified of the decision within thirty (30) days.

- **Hearing Aid:** An initial determination will be made within thirty (30) days from receipt of Your claim. If the Plan Administrator determines that additional time is necessary to make a determination due to matters beyond the control of the Plan, You will be notified within the initial thirty (30)-day deadline that up to fifteen (15) additional days may be needed. If additional information is needed to process Your claim, the initial period will be suspended, and You will be notified of the information that is needed. You then have up to forty-five (45) days from receipt of the notice to provide the requested information. After the information is received, but no more than forty-five (45) days after the request for information is made, a determination will be made and You will be notified of the decision within thirty (30) days.

- **Disability Claims:** An initial determination will be made within forty-five (45) days from receipt of Your claim. If the Plan Administrator determines that additional time is necessary to make a determination due to matters beyond the control of the Plan, You will be notified within the initial forty-five (45)-day deadline that up to thirty (30) additional days may be needed. If an additional thirty (30) days is needed, You will be notified within the first thirty (30)-day extension period. If additional information is needed to process Your claim, the initial period will be suspended, and You will be notified of what information is needed. You then have up to forty-five (45) days from receipt of the notice to provide the requested information. After the information is received, but no more than forty-five (45) days after the request for information is made, a determination will be made and You will be notified of the decision within thirty (30) days.

- **Life Insurance and AD&D Claims:** You or Your Beneficiary must call the Fund Office to request the appropriate claim forms. Complete the forms and submit them with the certified copy of the death certificate or documentation certifying the disability. A determination of Your claim will be made within forty-five (45) days of the receipt of Your claim. If additional information is needed, You will have up to forty-five (45) days to submit the requested information. During this time, the initial forty-five (45)-day period will be suspended until the requested information is received.

Payment of Benefits

If an individual dies before all amounts due have been paid, the Trustees, at their option, may make such payment to the individual's estate as determined under applicable law.

Any payment made by the Plan fully discharges the liability of the Trustees to the extent of such payment. However, self-funded benefits payable under the Plan are limited to the Plan assets available for payment of benefits.

If the Plan makes a payment due to mistake or fraud, the Plan is entitled to recover any payments from You, or to withhold future medical benefit payments otherwise payable to You or Your Dependents until the overpayment has been recovered by the Plan.

Non-Assignment of Benefits

Other than payments made directly to a Provider, You cannot assign Your benefits or other rights to which You are entitled under the Plan. You may lose Your Plan coverage if You attempt to assign or transfer coverage or aid any other person in fraudulently obtaining Plan coverage. The prohibition against assignment of rights includes rights to:

- Receive benefits;
- Claim benefits in accordance with Plan procedures and/or federal law;
- Begin legal action against the Plan, Trustees, Fund, its agents, or employees;
- Request Plan documents or other instruments under which the Plan is established or operated;
- Request any other information that a Participant or Beneficiary, as defined in ERISA, Section 102, may be entitled to receive upon written request to a Plan Administrator; and
- Any and all other rights afforded a Participant or Beneficiary under the Plan, Restated Trust Agreement, federal law, and state law.

The preceding restrictions on assignment of benefits do not preclude Your authorized representative from acting on Your behalf in pursuing a benefit claim or an appeal. To that end, the authorized representative, acting on Your behalf in pursuing an appeal, is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to Your claim for benefits, which may include, for example, Plan Documents, or excerpts of such documents.

Additionally, benefit payments are exempt from execution, attachment, garnishment, or other legal or equitable process for Your debts.

Appealing a Denied Non-Medical Benefits Claim

In most cases, disagreements about benefit eligibility or amounts can be handled informally by calling the Claims Administrator. If a disagreement is not resolved, You can follow the appeal procedure to have Your claim reconsidered.

If Your claim is denied (in whole or in part), You will be provided with certain information about Your claim within the timeframes previously described. When You are notified of an initial denial on Your claim, the notice will include:

- The specific reason(s) for the determination;
- Reference to the Plan provision(s) on which the determination was based;
- A description of any additional information or material needed to properly process Your claim and an explanation of the reason it is needed;
- A copy of the Plan's claims review procedures and time periods to appeal Your claim;
- A statement that You have a right to bring a civil action under ERISA Section 502(a) if Your claim was denied on appeal within one hundred eighty (180) days after the date of the appeal determination notice; and
- If Your claim is denied based on:
    - Any rule, guideline, protocol, or similar criteria, a statement that a copy of the rule, guideline, protocol, or similar criteria is available to You, at no cost, upon request; or
    - Medical Necessity, Experimental treatment, or similar exclusion or limit, a statement that You may request a copy, at no cost, of any explanation of the scientific or clinical judgment on which the denial was based.

- As to Disability Benefit claims, the Claims Administrator, other adjudicators, medical experts and vocational experts involved in deciding a claim for Disability Benefits will be independent and impartial, as set forth in applicable ERISA regulations.

- If an expert report or opinion is obtained in rendering the initial Disability Benefit claim determination, and if Your Disability Benefit claim is denied, the initial denial notice will provide You the right to obtain a copy of any such expert opinion or report.

- If the appeal of an adverse Disability Benefit determination is based (in whole or in part) on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the adjudicator deciding the Disability Benefit claims appeal shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The expert must be independent and impartial.

- If You appeal the initial denial of a Disability Benefit, and if the Board of Trustees or other adjudicator of Your appeal obtains new or additional evidence relevant to the Disability Benefit claim, or if they obtain a new rationale for responding to the Disability Benefit claim, the Plan shall automatically provide such information to You and provide You the right to respond to such evidence or rationale, prior to the Plan rendering its final appeal decision on your Disability Benefit claim appeal.

Appealing a Denied Claim to The Board of Trustees

If Your claim is denied (in whole or in part) or You disagree with the Plan's determination regarding Your eligibility for benefits or the amount of the benefit, You have the right to have the initial determination reviewed. You must follow the appeals procedure before You file a lawsuit under ERISA, the federal law governing employee benefits.

You may authorize a representative to act on Your behalf for a claim or appeal (see page 80).

In general, You should send Your written request for an appeal to the Board of Trustees at the address of the Plan Administrator as soon as possible. If Your claim is denied or if You are otherwise dissatisfied with a determination under the Plan, You must file Your written appeal within one hundred eighty (180) days after You receive the notice of denial. Your written appeal must explain the reasons You disagree with the determination on Your claim and You may provide any supporting documents or additional comments related to this review. When filing an appeal You may:

- Submit additional materials, including comments, statements, or documents;
- Request to review all relevant information (free of charge);
- Request a copy of any internal rule, guideline, protocol, or other similar criteria on which the denial was based; and
- If Your appeal is denied based on Medical Necessity, Experimental treatment, or similar exclusion or limit, request a copy, at no cost, of any explanation of the scientific or clinical judgment on which the denial was based.

Appeal Determinations

If You file Your appeal on time and follow the required procedures, a new, full, and independent review of Your claim will be made and the determination will not be based on the initial benefit determination. The Board of Trustees will conduct the review and the determination will be based on all information used in the initial determination as well as any additional information submitted. The Board of Trustees meet monthly. You will be notified, in writing, of the determination on Your appeal no later than five (5) days after the determination is made, as set forth in the timeframes below. However, oral notice of a determination on Your urgent care claim may be provided to You sooner.

Appeal Determination Timeframes

A determination will be made at the Board of Trustees next regularly scheduled monthly meeting following receipt of Your appeal. However, if the request is filed within thirty (30) days of the date of the meeting, the determination may be made at the second meeting following receipt of Your appeal. If special circumstances require a further extension, a determination will be made at the third meeting following receipt of Your appeal. You will be notified if any extension is necessary. The notice will state the special circumstances and the date the Plan expects to make a determination.

Medical Judgments

If Your claim or appeal is denied based on a medical judgment, the Plan Administrator and/or the Board of Trustees will consult with a health care professional who:

- Has appropriate training and experience in the field of medicine involved in the medical judgment; and
- Was not consulted (or is not subordinate to the person who was consulted) in connection with the denial of Your claim.

You have the right to be advised of the identity of any medical professionals consulted in making a determination of Your appeal.

Authorized Representatives

When making a claim for benefits or appealing the denial of a claim for benefits, You may authorize a representative to act on Your behalf. You must provide written notification authorizing this representative. The written notification must include the individual's name, address, and phone number. However, if You are unable to provide a written statement, the Plan requires other written proof (such as power of attorney for health care purposes or court order of guardian/conservator) that the proposed authorized representative has been authorized to act on the individual's behalf.

Authorized representatives may include a:

- Health care Provider that has knowledge of the condition;
- Spouse;
- Dependent Child age eighteen (18) or over;
- Parent or adult sibling;
- Grandparent;
- Court-ordered representative, such as an individual with power of attorney for health care purposes, legal guardian, or conservator; or
- Other adult.

Once a representative is authorized, future claims and appeals-related correspondence will be sent to the authorized representative. The Plan will recognize the designated authorized representative for one year, or as mandated by a court order, before requiring a new authorization. However, the individual may revoke a designated authorized representative at any time by submitting a signed statement.

The Plan Administrator or its designated representative has the discretion to determine whether an authorized representative has been properly designated in accordance with the Plan's terms. The Plan Administrator reserves the right to withhold information from a person who claims to be an authorized representative if there is suspicion about the qualifications of that individual.

Trustee Authority and Interpretation

The Trustees or, where Trustee responsibility has been delegated to others including but not limited to the Plan Administrator or, such other persons, will be the sole judges of the standard of proof required in any case and the application and interpretation of this Plan. The decisions of the Trustees or their delegates are final and binding. Benefits under this Plan will be paid only when the Board of Trustees, or persons delegated by them, decides, in their discretion, that the Participant or Beneficiary is entitled to benefits in accordance with the terms of the Plan. In the event a claim for benefits has been denied, no lawsuit or other action against the Fund or its Trustees may be filed until the matter has been submitted for review under the ERISA-mandated review procedure adopted by the Trustees, from time to time. The decision on review is binding upon all persons dealing with the Plan or claiming any benefit hereunder, and is to be accorded judicial deference in any court or administrative proceeding, 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.

You or any other claimant may not begin any legal action related to the denial of a non-medical claim (a claim for Dental Care, Hearing, Vision Care, Medical Eligibility Bank, SUB/ME, Disability, Life Insurance or Jury Duty), including proceedings before administrative agencies, until You have followed and exhausted the procedures described in this section. No such action may be brought more than one hundred eight (180) days after the date of the appeal determination notice. If You do not include any theories or facts in Your written claim or appeal, they will be waived. In other words, You will lose the right to raise factual arguments and theories that support Your claim if You do not include them in Your written claim or appeal. At Your own expense, You may have legal representation at any stage of the review process.

Payment of Claims

Manner of Claims Payment

The Plan reserves the right to pay eligible claims in any one or more (including a combination thereof) of the following methods:

- Directly to the service Provider without regard to whether or not there has been an assignment of benefits, provided that the service Provider confirms in writing that it has not been paid for the part of the outstanding claim to be paid to it;
- As reimbursement to any Participant provided that the claim has been paid by him or her;
- To any third party (including a Dependent of a Participant or other Plan Beneficiary) who establishes to the satisfaction of the Plan in writing that such third party has paid part or all of the claim to be reimbursed. Such reimbursement shall not exceed the amount paid by such third party;
- Directly to Participant for a claim under the Disability Benefits or AD&D Benefits and/or
- Directly to Beneficiary if Participant is deceased.

If the Fund determines that the Participant or Beneficiary is not legally able to receive such payment, the Fund may, at its option, pay the benefits to the Participant or Beneficiary's estate or to any or all of the following relatives of the Participant:

- Spouse;
- Child(ren);
- Parent(s);
- Brother(s);
- Sister(s).

Any payment made under this option will completely discharge the Fund from further obligation for such payment.

Overpayment of Claims

Any overpayment of claims shall be returned to the Plan by the person or entity (whether it be You, Your Dependent, or a Beneficiary, a service Provider or a third party) to whom the overpayment was made. Any overpayment not refunded to the Plan (regardless of whether or not the Participant or Beneficiary has been notified in writing of such overpayment) shall be deducted from future benefits due the Participant or Beneficiary upon whose behalf such overpayment was made. Overpayments made on behalf of a Dependent may be deducted from Your, Your Dependent's, or Your Beneficiary's future benefits. If You have balances in either Your Medical Eligibility Bank Account or in Your SUB/ME Accounts, any overpayments related to You, Your Dependent, or Your Beneficiary may be deducted and reimbursed to the Plan through such account balances without prior notice.

In cases where You and Your Spouse are separated or divorced, overpayments may only be deducted from future benefits due the individual (including such Children as may be in the custody of such individual) who received the overpayment, provided, however, that any overpayments made to You or Children in Your custody may also be deducted from Your Medical Eligibility Bank or SUB/ME account balances without prior notice.

Subrogation and Reimbursement

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 Subrogee has a right of redress against any third-party. For purposes of this Subrogation and Reimbursement section, Subrogee means the participant, employee, dependent, beneficiary, representative (including a trustee in a wrongful death action), an administrator of an estate or any other person asserting a claim related to the injury, claim, action or occurrence under this section.

What does first priority right of subrogation and reimbursement mean? It means that if the Plan pays benefits which are, in any way, compensated by a third-party, such as an insurance company, the Subrogee 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 Subrogee 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 a Subrogee is injured at work, in an automobile accident, at a home or business, in an assault, as a result of medical or other negligence, 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 Subrogee 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 Subrogee in recognition of the fact that the value of benefits provided to each employee or dependent will be maintained and enhanced by enforcement of these rights.

Subrogation and Reimbursement – Rules for the Plan

Subrogation
A rule that gives the Plan the right to be repaid for benefits it pays on a claim if a third party is responsible for paying the expenses for which the claim is made.
You must avoid doing anything that would prejudice the Plan's right of Subrogation, Repayment and lien. In the event there is a claim against a third party, You must promptly advise the Fund.

The following rules apply to the Plan's right of subrogation and reimbursement:

1. Subrogation and Reimbursement Rights in Return for Benefits: In return for the receipt of benefits from the Plan, the Subrogee agrees that the Plan has the subrogation and reimbursement rights as described in this Subrogation and Reimbursement section. Further, the Subrogee and their attorney will sign a Subrogation Agreement with the Plan acknowledging the Plan's subrogation and reimbursement rights prior to payment, or further payment, of benefits directly resulting from an injury, occurrence or condition for which the Subrogee has a right of redress against any third party. Benefits will not be paid if the Subrogee and/or their attorney refuses to sign the Subrogation Agreement. 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 Subrogee and (if represented) their attorney refuses to sign the Subrogation Agreement. Should the Subrogee and/or their attorney fail to sign the required Subrogation Agreement, the Plan reserves the right to take any and all action necessary to protect its subrogation and reimbursement rights for benefit claim payments related to an injury, occurrence or condition for which the Subrogee has a right of payment from a third party; including denying the payment of benefits, offsetting any future benefits payable under the Plan, recouping any benefits previously paid, suspending and/or terminating coverage under the Plan.

2. Plan Granted 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 Subrogee from a third-party, whether by settlement, judgment or otherwise and in consideration for the payment of benefits, the aforementioned individual(s) agree to the same. 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 Subrogee 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, and at the discretion of the Trustees, pursue all available equitable remedies, pursue all available legal remedies, offset any benefits payable under the Plan, recoup any benefits previously paid, suspend all benefits available under the Plan, or terminate coverage of the Subrogee or Subrogees.

3. Subrogee Contructive Trust and/or Equitable Lien Duties: The Subrogee is required to use his or her best efforts to preserve the Plan's right of subrogation and reimbursement. This will include, but not be limited to, the Subrogee's causing of the Plan's subrogation or reimbursement interest to be paid to the Plan, advising their legal counsel to segregate the Plan's subrogation or reimbursement interest to be held in such legal counsel's trust account until the Plan's interest is agreed to or completely adjudicated, and not allowing any other disbursement from any settlement or judgment proceeds to Subrogee, Subrogee's attorney, or any other third-party, prior to complete disbursement to the Plan. Should Subrogee fail to use their best efforts to preserve the Plan's right of subrogation and reimbursement, including but not limited to, the actions set-forth in paragraph (2) above as well as the entirety of these subrogation provisions and the terms of the Plan as a whole, Subrogee's coverage under the Plan will terminate until such time as the Plan is made whole, including the reimbursement of all interest, attorney's fees and costs reasonably incurred. Only upon the Plan's being made whole may the Subrogee make application to the Board of Trustees of the Plan for reinstatement of their coverage.

4. Plan Paid First: Amounts recovered or recoverable by or on the Subrogee'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 Subrogee. The Plan's subrogation and reimbursement right comes first even if the Subrogee 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 Subrogee may have received or may be entitled to receive from the third-party.

5. 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 can bring an action (including in the Subrogee's name) for, breach of contract, specific performance, injunction or any other equitable action necessary to protect its rights in the cause of action, right of recovery or recovery by a Subrogee. The Plan will commence any action it deems appropriate against a Subrogee, 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 dependent is legally obligated for expenses of treatment.

6. 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 Subrogee has or may have against any third-party, regardless of whether such person or entity has the right, legal or otherwise, to recover the medical expenses paid by the Plan.

7. No Assignment: The Subrogee 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.

8. Full Cooperation: The Subrogee will cooperate fully with the Plan and do nothing to prejudice or adversely affect the Plan's subrogation and reimbursement rights. Benefits will be denied or recouped if the Subrogee does not cooperate with the Plan. This includes, but is not limited to, responding to any Plan request for information and updates.

9. Notification to the Plan: The Subrogee must promptly advise the Plan Manager, in writing, of any claim being made against any person or entity to pay the Subrogee for their injuries, sickness, or death. Further, the Subrogee must periodically update the Plan regarding the claim and notify the Plan of a settlement prior to reaching a compromise of their claims. The Subrogee must promptly notify the Plan

Manager, in writing, with the name, address and telephone number of their attorney in the event a claim is pursued.

10. Third-Party: Third-party includes, but is not limited to, all individuals, entities, federal, state or local governments, and insurers (including, but not limited to, liability, medical expense, wage loss, workers' compensation, premises liability, no-fault, uninsured or underinsured motorist insurers), who reimburse, compensate, pay or are liable for a Subrogee'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 Subrogee.

11. Apportionment, Comparative Fault, Contributory Negligence, Make-Whole and Common-Fund Doctrines Do Not Apply: The Plan's subrogation and reimbursement rights include all portions of the Subrogee'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 make-whole and common-fund doctrines or any other equitable defenses.

12. Attorney's Fees: The Plan will not be responsible for any attorney's fees or costs incurred by the Subrogee in any legal proceeding or claim for recovery, 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.

13. Course and Scope of Employment: If the Plan has paid benefits for any injury which may have arisen 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 Subrogee 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 Subrogee's attorney from the Plan's recovery, the Subrogee will reimburse the Plan for the attorney's fees.

Administrative Information

Plan Sponsor

The Plan is sponsored and administered by the Joint Board of Trustees. The Board of Trustees consists of Employer and Union representatives selected by the Employers and Unions who have entered into Collective Bargaining Agreements that relate to this Plan. If You wish to contact the Board of Trustees, You may contact the Fund Office at the contact information below:

St. Paul Electrical Workers' Health Plan
1330 Conway Street, Suite 130
St. Paul, MN 55106
Phone: 651-776-4239
Fax: 651-772-8791

Board of Trustees is:

Employer Trustees	*Union Trustees*
Mr. Luke M. Kuhl	Mr. James C. Schult
Mr. J.T. Pedersen	Mr. Doug W. Suchanek
Mr. Peter B. Bourland	Mr. Brandon P. Anderson

Administrative Manager

The Board of Trustees has delegated administrative responsibilities to other individuals or organizations as follows:

- The Plan Administrator, Wilson-McShane Corporation, maintains eligibility records, accounts for Employer Contributions, answers Participant inquiries, and handles other administrative functions.
- The Fund's auditor, CliftonLarsonAllen, LLP is responsible for preparing certain required government reports.

Plan Name

The name of the Plan is the St. Paul Electrical Workers' Health Plan.

Together the Plan's name, number, and the Trustee's EIN identify the Plan with government agencies.

Plan Numbers

The employer identification number (EIN), assigned to the Board of Trustees by the Internal Revenue Service, is 41-1365924. The Plan number assigned by the Board of Trustees is 501.

Plan Privacy Officer

The Plan's Privacy Officer is Martin C. Lasley, who may be contacted at the Fund Office.

Plan Security Officer

The Plan's Security Officer is Brian McCumber, who may be contacted at the Fund Office.

Legal Counsel

McGrann Shea Carnival Straughn & Lamb, Chartered
800 Nicollet Mall, Suite 2600
Minneapolis, MN 55402

Consultant

United Actuarial Services

Parties to the Collective Bargaining Agreement

The Plan is maintained pursuant to a collective bargaining agreement. You and Your Dependent may obtain, upon written request to the Fund Office, information as to the name and address of a particular employer and whether an employer is required to pay Contributions to the Plan, or may obtain a list of all contributing employers and unions maintaining the Plan. You may also request a copy of the Collective Bargaining Agreement.

Agent for Service of Legal Process

The Plan Administrator is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon:

St. Paul Electrical Industry
Administrative Service Corporation
1330 Conway Street, Suite 130
St. Paul, MN 55106.

However, such documents may also be served upon any individual Trustee.

Plan Funding

Employer Contributions and certain Self-Payments finance the benefits described in this booklet. All Employer Contributions and Self-Payments are paid to the Trust Fund subject to provisions in the Collective Bargaining Agreements. A copy of the Collective Bargaining Agreement under which You are covered is available, upon written request, from the Plan Administrator and is available for examination at the Fund Office.

The labor agreements specify the amount and due date of Employer Contributions, type of work for which Contributions are payable, and the geographic area covered by these labor agreements.

Medical benefits are self-insured and administered by the Plan Administrator, Wilson-McShane Corporation.

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

The Plan's benefits listed below are self-funded from accumulated assets and are provided directly from the Trust Fund. A portion of Fund assets is allocated for reserves to carry out the objectives of the Plan.

Self-funded benefits include:

- Medical Benefits
- Dental Benefits
- Hearing Aid Benefits
- Disability Benefits
- Jury Duty Benefits
- SUB/ME Benefits
- Medical Eligibility Bank TEAM Employee Assistance Plan
- TRIA Neck & Back Advantage Program
- EPIC Hearing
- Vision Service Plan Program

The Board of Trustees holds all assets in trust. Benefits, medical premiums, and administrative expenses are paid from the Trust.

Insured benefits include:

- Life Insurance; and
- Retiree Supplemental Medicare Coverage.

Plan Year

The records of the Plan are kept on a fiscal year basis, beginning each October 1, and ending September 30.

Plan Type

This Plan is considered a welfare plan, providing medical, prescription drug, hearing, vision, disability, unemployment and jury duty benefits for You and Your Dependents who meet the eligibility requirements described in this booklet.

Eligibility Requirements

A summary of the Plan's requirements for eligibility for benefits is shown in this booklet. Circumstances that may cause You to lose eligibility are also explained. Your coverage by this Plan does not constitute a guarantee of Your continued employment and You are not vested in the benefits described in this booklet. All Plan benefits are made available to You and Your Dependents by the Plan as a privilege and not as a right.

Workers' Compensation and the Plan

The Plan does not replace and is not affected by any requirement for coverage under workers' compensation or any occupational disease act or similar law. Benefits that would otherwise be payable under the provisions of such laws are not paid by the Plan.

Plan Amendment and Termination

The Board of Trustees have the authority to increase, decrease, or change benefits, eligibility rules, or other provisions of the Plan of Benefits as they may determine in their discretion to be in the best interests of Plan Participants and Beneficiaries. Any such amendment, which will be communicated to You in writing, will not affect valid claims that originated before the date of the amendment.

This Plan may be discontinued or terminated. In such event, all coverage for Participants and their Dependents will end as of the date of termination. Any such discontinuation will not affect valid claims that originate before the termination date of the Plan as long as the Plan's assets are more than the Plan's liabilities. Full benefits may not be paid if the Plan's liabilities are more than its assets, and benefit payments will be limited to the assets available in the Trust Fund for such purposes. The Trustees will not be liable for the adequacy or inadequacy of such assets. If there are any excess assets remaining after the payment of all Plan liabilities, those excess assets will be used for purposes determined by the Trustees in accordance with the provisions of the Trust Agreement.

Board of Trustees' Discretion and Authority

All benefits under the Plan are subject to the Trustees' authority under the Trust Agreement. However, the Trustees intend that the Plan terms, including those relating to coverage and benefits, are legally enforceable and that the Plan is maintained for the exclusive benefit of the Participants and Beneficiaries.

Under the Plan of Benefits and the Trust Agreement creating the Plan, the Trustees or persons acting for them, such as the Plan Administrator, have sole authority to make final determinations regarding any application for benefits and the interpretation of the Plan of Benefits, the Trust Agreement, and any other regulations, procedures, or administrative rules adopted by the Trustees. Decisions of the Trustees (or where appropriate, decisions of those acting for the Trustees) in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. The Trustees will make every effort to interpret Plan provisions in a consistent and equitable manner and the Trustees' decisions will be afforded judicial deference. Benefits under this Plan will be paid only when the Board of Trustees (or persons delegated by the Trustees) decides, in their discretion, that the Participant or Beneficiary is entitled to benefits in accordance with the Plan's terms.

If a decision of the Trustees or those acting for the Trustees is challenged in court, it is the intention of the parties to the Trust that such decision is to be accorded judicial deference and upheld unless it is determined to be arbitrary or capricious.

Benefits provided to different classes of Participants may vary. In addition, any required contributions might vary depending on the benefits provided and other factors.

Your ERISA Rights

As a Participant in the Plan, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants be entitled to the following rights.

Receive Information about Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA);

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description (the Plan Administrator may make a reasonable charge for the copies); and

- Receive a summary of the Plan's annual financial report, which the Plan Administrator is required by law to provide to each Participant.

Continue Group Health Plan Coverage

You also have the right to:

- Continue health care coverage for Yourself, Spouse, or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event (You or Your Dependents may have to pay for such coverage; review this Summary Plan Description and any documents governing the Plan on the rules governing Your COBRA Continuation Coverage rights.); and

- Reduce or eliminate exclusionary periods of coverage for preexisting conditions under Your group health plan, if You have creditable coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from Your group health plan or health insurance issuer when:

    - You lose coverage under the Plan;
    - You become entitled to elect COBRA Continuation Coverage; or
    - Your COBRA Continuation Coverage ends.

You may obtain a Certificate of Creditable Coverage upon written request to the Plan Administrator. Your request may be hand-delivered or sent by mail. Certificates will be sent to You by first-class mail to Your last known address, unless a Dependent is known to reside at a different address, in which case the Certificate for that Dependent will be sent to that address.

You may also request the Certificate of Creditable Coverage before losing coverage or within twenty-four (24) months after losing coverage. Without evidence of creditable coverage, You may be subject to a preexisting condition exclusion for twelve (12) months (eighteen (18) months for late enrollees) after Your enrollment date in Your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate Your Plan, called

fiduciaries of the Plan, have a duty to do so prudently and in the interest of You and other Plan Participants and Beneficiaries. No one, including Your Employer, Your Union, or any other 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.

Enforce Your Rights

If Your claim for a welfare benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of the Plan Documents or the latest annual report from the Plan and do not receive them within thirty (30) days, You may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to One Hundred Ten Dollars ($110) a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If You have a claim for benefits that is denied or ignored, in whole or in part, You may file suit in a state or federal court. However, You may not begin any legal action, including proceedings before administrative agencies, until You have followed and exhausted the Plan's claims and appeals procedures (see pages 50 and 51). In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a medical Child support order, You may file suit in federal court. If You believe that Plan fiduciaries have misused the Plan's money, or if You believe that You have been discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a federal court. The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

Assistance with Your Questions

If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, You should contact the nearest office of the EBSA, U.S. Department of Labor, listed in Your telephone directory or at:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

For more information on Your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by:

- Calling 866-444-3272; or
- Visiting the Web site of the EBSA at www.dol.gov/ebsa.

Glossary

Acute Injury means any bodily Injuries wherein the patient has been seen by a Physician within one hundred twenty (120) hours of the accident and has been treated, other than Injuries that occur in the commission of a crime, except that Injuries incurred as a result of acts of domestic violence will be covered.

Allowed Amount is the negotiated amount of Covered Charges charged by an In-Network Provider for each service or product. For Out-of-Network Providers, it is the lesser of the billed amount or the amount as determined by the Claims Administrator and UMR of Minnesota, which may be calculated by UMR of Minnesota using several methods. Out-of-Network Providers may charge more than the Allowed Amount and the Allowed Amount for an Out-of-Network Provider may be different from the same service by an In-Network Provider. The Plan will only pay for any Out-of-Network claims the lesser of the amount the Out-of-Network Provider charges or 180% of the Medicare Like Rates (MLR) for the claim.

Beneficiary is person designated by a Participant, or by the terms of an employee benefit plan, who is or may become entitled to a death benefit or benefit after Participant's death thereunder.

Child means an individual who meets the requirements of (a) – (c) below:

a. A Participant's natural Child, stepchild or legally adopted Child (from the date of placement) from live birth until the date the Child attains age 26.

b. A Child shall mean a Qualified Alternate Recipient recognized by a Qualified Medical Child Support Order (QMCSO), a certified copy of which is on file with the Fund Office. QMCSO filing procedures are available at the Fund office.

c. A Child shall mean an unmarried handicapped dependent Child of Participant who reaches age twenty-six (26) while covered under this Plan if all of the following apply:

   - The Child is primarily Dependent upon Participant; and
   - The Child is incapable of self-sustaining employment because of physical handicap, mental retardation, mental Illness, or mental disorders; and
   - Participant has applied for extended coverage of the Child as a handicapped dependent Child within thirty-one (31) days after reaching the age limit. After this initial proof, the Plan may request proof again two (2) years later, and each year thereafter; and
   - The Child became handicapped prior to reaching age 26.

Co-insurance means the percentage of the Allowed Amount You must pay for certain Covered Charges. Co-insurance applies after any applicable Deductible and Co-payments up to the Out-of-Pocket Maximum. Co-insurance for Medical is tracked separately from Co-insurance for Prescription Drugs. Medical Payments and Prescription Drugs have separate Out-of-Pocket Maximums.

Co-pay or Co-payment means a set dollar amount for which the Participant or Dependent are responsible. Co-payments are generally due at the time the service is rendered, or a Supply or drug is provided. Co-payments do not count toward satisfying any Deductible, but do count toward satisfying the Out-of-Pocket Maximum.

Cosmetic means surgery or other treatment for the primary purpose of making a person better looking, unless such surgery or treatment is permitted under the Code § 213, or the Women's Health and Cancer Rights Act, or other federal law.

Covered Charges means the Allowed Amount for Medically Necessary Services, supplies and treatments which are covered by this Plan for medical conditions covered by this Plan and are in accordance with accepted standards of medical practice.

Covered Employment means employment of a person by a firm, organization or association signatory to a collective bargaining agreement between Local Union 110 and St. Paul NECA or an agreement approved

by the Trustees where such firm, organization or association is obligated to make contributions to the Plan on behalf of the employees.

Custodial Care means treatment, Services or confinement, regardless of who recommends, prescribes or performs them, or where they are provided, which could be rendered safely and reasonably by a person not medically skilled, and are designed mainly to help the patient with daily living activities. Custodial Care includes:

- Personal care such as help in: walking, getting in and out of bed, bathing, eating (including tube gastrostomy), exercising, dressing, using the toilet or administration of an enema;
- Homemaking such as preparing meals or special diets;
- Moving the patient;
- Acting as a companion or sitter;
- Supervising medication which can usually be self-administered;
- Chronic health care not anticipated to improve the medical condition of the Participant, such as Respite Care provided to assist regular care givers of a Participant; or
- Repetitive and duplicative care that does not require the assistance of a skilled medical professional. This care does not seek to cure, but to stabilize and assist with daily living activities.

The Plan Administrator shall have the discretion to determine which Services are Custodial Care. The determination of Custodial Care in no way implies that the care being rendered is not required by the patient; such a determination only means that it is the kind of care that is not covered by this Plan and will not be reimbursed by this Plan.

CT Scan or **CAT Scan** means computerized tomography x-ray technology.

Day Treatment means behavioral health Services that may include a combination of group and individual therapy or counseling for a minimum of three (3) hours per day, three (3) to five (5) days per week.

Dependent means the Participant's legally married Spouse or the Participant's Child.

Deductible means the amount You must pay toward the Allowed Amount for certain covered Services each year before the Plan begins to pay benefits. Deductible payments are tracked In-network and Out-of-Network only for purposes of application to the appropriate Out-of-Pocket Maximum. Any Deductible payment, whether it is In-Network or Out-of-Network, is counted toward satisfying the applicable individual and family Deductible limits.

Doctor or Physician means a person duly licensed as a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.). The term "Physician" shall include a duly licensed chiropractor or other certified medical practitioner, required by state law, for Services which are both within the scope of the license or certificate.

Early Retirement means the cessation of active employment in the Electrical Industry any time after attaining the age 55.

Elective means subject to the choice or decision of the patient or Physician, applied to procedures that are only advantageous to the patient but not Medically Necessary for the treatment of Illness or Injury.

Electrical Industry means all employers who perform the following types of work within the geographical jurisdiction of IBEW Local 110.

- Installing, connecting, shifting, repairing, and wiring, whether of a temporary or permanent nature, in connection with electrical lighting, heat, power control, signaling, and data transfer.
- Maintenance and repair of electrical equipment and installations.
- Related work that includes opening and closing of places for electrical work, handling and moving of all electrical materials and equipment and the fabrication of electrical materials.

E-Visit means a patient-initiated, limited online evaluation and management health care service provide by a Physician or other qualified health care Provider using the internet or similar secure communications network to communicate with an established patient.

Experimental or **Investigative Service** or **Supply** means a drug, device, or medical treatment or procedure:

- If the drug or device cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- If the drug, device, medical treatment or procedure, or the patient informed-consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating Facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinical trials, is the research, Experimental, study or investigational arm of ongoing phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
- If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with standard means of treatment or diagnosis.

Facility means a Provider that is a Hospital, Skilled Nursing Facility, residential treatment center, Residential Behavioral Health Treatment Facility, or outpatient behavioral health treatment Facility licensed under state law, in the state in which it is located to provide the health Services billed by that Facility. Facility may also include a licensed home infusion therapy Provider, freestanding ambulatory surgical cent, Home Health Agency, or freestanding birthing center when Services are billed on a Facility claim.

Family Therapy means behavioral health therapy intended to treat an individual, diagnosed with a mental health condition or chemical dependency condition, within the context of family relationships.

Foot Orthoses means appliances or devices used to stabilize, support, align, or immobilize the foot in order to prevent deformity, protect against Injury, or assist with function.

Formulary means a list of U.S. Food and Drug Administration (FD))-approved prescription drugs and supplies developed by CVS Caremark, which classifies medications for purposes of benefit design.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from the individual or a family member. It includes any information about an individual's genetic tests, the genetic tests of family members of such individual and the manifestation of a disease or disorder in family members of such individual. It includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes. Any reference to Genetic Information concerning an individual or family member includes Genetic Information of a fetus carried by a pregnant woman and an embryo legally held by an individual or family member utilizing an assisted reproductive technology.

Habilitative Services means Services, including devices, that are expected to make measurable or sustainable improvement within a reasonable period of time and assist a member to attain, maintain, or improve daily living skills or functions never learned or acquired due to a disabling condition.

Halfway House means specialized residences for individuals who no longer require the complete facilities of a Hospital or institution but are not yet prepared to return to independent living.

Home Area means the geographic area in which a Participant is employed by a firm, organization, or association signatory to or otherwise obligated under the labor agreement between the St. Paul Chapter, National Electrical Contractors Association and Local Union No. 110, IBEW

Home Health Agency means a Medicare approved or other preapproved Facility that sends health professionals and Home Health aides into a person's home to provide health Services.

Hospice Care means a coordinated set of Services provided at home or in an institutional setting for covered individuals suffering from a terminal disease or condition.

Hospital means a licensed medical care Facility that: maintains permanent full-time facilities for bed care of resident patients; has a Physician and surgeon in regular attendance; provides continuous twenty-four (24)-hour a day nursing Services; is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons; and is legally operated in the jurisdiction where it is located and has surgical facilities on its premises or has a contractual agreement for surgical Services within an institution having a valid license to provide such surgical Services.

Hospital does not include an institution that is principally a Skilled Nursing Facility, rest home, nursing home, convalescent home, or home for the aged.

Illness means a sickness, pregnancy, mental Illness, Substance Abuse, or condition involving a physical disorder.

Injury or **Injuries** means bodily Injuries other than Injuries that occur in the commission of a crime except that Injuries incurred because of acts of domestic violence will be covered.

In-Network Providers are Providers who maintain a contract with UnitedHealthcare (UMR-MN) and who serve as a participating Provider as part of a network available to the plan through UMR-MN.

Inpatient Stay means a stay in a Hospital, Skilled Nursing Facility, or licensed residential treatment center or a licensed behavioral health treatment center that exceeds a period of twenty-four (24) hours.

Medical Necessity or Medically Necessary means medical care and treatment that meets all the following conditions:

- A health intervention for the purpose of treating a medical condition.
- The most appropriate Supply or level of service, considering potential benefits and harms to the patient.
- Known to be effective in improving health outcomes. For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion.
- Cost-effective for this condition compared to alternative interventions, including no intervention. "Cost-effective" does not necessarily mean lowest price.
- It is specifically allowed by the licensing statutes that apply to the Provider that renders the service.
- With respect to confinement in a Hospital, Medical Necessity further means that the medical condition requires confinement, and that safe and effective treatment cannot be provided as an outpatient.

The Plan has retained UMR as the medical network provider for the Plan's medical benefits. Unless otherwise stated in the Plan, in determining whether a treatment or service is Medically Necessary under the Plan's medical benefits, the Board of Trustees will rely upon UMR to make such determinations consistent with UMR's medical policies which are also herein incorporated into the Plan by reference.

Mental Health Professional means a psychiatrist, psychologist, licensed independent clinical social worker, marriage and family therapist, nurse practitioner or a clinical nurse specialist licensed for independent practice that provides treatment for mental health disorders.

Mental Illness means a mental disorder as defined in the International Classification of Diseases. It does not include alcohol or drug dependence, nondependent abuse of drugs, or developmental disability.

MRI means magnetic resonance imaging technology.

Network Provider is a healthcare Provider that has signed an agreement with the network to provide Services at negotiated rates.

Non-Bargaining Unit Employee is any person regularly employed by a firm, organization, or association, located within the geographical jurisdiction, and signatory to or otherwise obligated under, and in compliance with an agreement between the St. Paul Chapter, NECA., and Local Union No. 110, IBEW, in a capacity not coming under the terms of a collective bargaining agreement between said Chapter and Local Union. Also included in this category are employees of the two sponsoring organizations and any other Related Organization so approved by the Trustees who are not Regular Employees, including electrical inspectors contracted by the State of Minnesota or other municipalities performing electrical inspections within the jurisdiction of IBEW Local Union 110. A person who has entered into a Salting Agreement with the Union shall be considered a Non-Bargaining Unit Employee. The Union's Business Manager and his or her appointed representatives shall not be considered Non-Bargaining Unit Employee, but are classified as Regular Employees.

Non-Network Provider is a healthcare Provider that has not signed an agreement with the network and may charge rates that are beyond the negotiated rates.

Normal Retirement means for Regular Employees or Non-Bargaining Unit Employees the cessation of employment in the Electrical Industry after attaining age 65.

Out-of-Network Providers are Providers who do not have a contract with the network providers retained by the Plan. They are Non-participating Providers.

Out-of-Pocket Maximum means the most each Participant must pay each Calendar Year toward the Allowed Amount for covered Services. After a Participant reaches the Out-of-Pocket Maximum, the Plan pays one hundred percent (100%) of the Allowed Amount for covered Services for that person for the rest of the calendar year. In-network Co-pays, Deductibles and Co-insurance count toward in In-network Out-of-Pocket Maximum, Out-of-Network Co-pays, Deductibles and Co-insurance count toward Out-of-Network Out-of-Pocket Maximums. There is a separate Out-of-Pocket Maximum for Prescription Drugs, and out-of-pocket costs related to prescription drugs are tracked separately.

Outpatient Behavioral Health Treatment Facility means a Facility that provides outpatient treatment, by or under the direction of, a Doctor of Medicine (M.D.) or Osteopathy (D.O.), for mental health disorders, alcoholism, Substance Abuse, or drug addiction. An outpatient behavioral health treatment Facility does not, other than incidentally, provide educational or recreational Services as part of its treatment program.

Outpatient Care means health Services a patient receives without being admitted to a Facility as an Inpatient. Care received at ambulatory surgery centers is considered Outpatient Care.

Palliative Care means care for a Participant with an Illness that does not go away and often gets worse with time. The goal of palliative care is to improve quality of life. Palliative care services in a Hospital, in Skilled Nursing facility or Hospice facilities is covered by the Plan.

Participant means any Regular Employee or Non-Bargaining Unit Employee or Retiree who has met the eligibility requirements for the Plan, whose coverage has become effective, and whose coverage has not been terminated under any provision of the Plan.

Professional Ambulance Service means transportation by a vehicle especially equipped for the conveyance of the injured, or sick.

Provider means a health care professional licensed, certified or otherwise qualified under state law, in the state in which Services are rendered to provide the health Services billed by that Provider and a health care

Facility licensed under state law in the state in which it is located to provide the health Services billed by that Facility. Provider includes pharmacies, medical Supply companies, independent laboratories, ambulances, freestanding ambulatory surgical centers, home infusion therapy Providers, and also Home Health Agencies.

Qualified Medical Child Support Order (QMCSO) means a court order specifying legal responsibility for health care benefits for a Child whose parents are separated or divorced.

Reciprocal Area means any geographic area in which a Participant is employed by any firm, organization or association signatory to, or otherwise obligated under an agreement with the International Brotherhood of Electrical Workers (IBEW) or any local thereof, and with such labor agreement or entity created therein has reciprocal agreement with the Trustees of the St. Paul Electrical Workers' Health Plan to remit contributions on behalf of said Participant to This Plan.

Regular Employee is any person who is employed under the provisions of a collective bargaining agreement between Local Union No. 110, IBEW and the St. Paul Chapter, NECA., or such other Local Union No. 110, IBEW Labor agreement approved by the Trustees. Regular Employee will not include a Non-bargaining Unit employee, or an employee who, by agreement between the Union and the Employer, does not have contributions made to the Plan on his behalf, or who, by agreement through good faith collective bargaining, is excluded from coverage under this Plan. The Union's Business Manager and their appointed representatives are considered Regular Employees.

Rehabilitative Services means Services, including devices, that are expected to make measurable or sustainable improvement within a reasonable period of time and assist a member to regain, maintain, or prevent deterioration of daily living skills or functions acquired but then lost or impaired due to an Illness, Injury, or disabling condition.

Related Organization means any organization established for assisting eligible employees and employers with matters relating to the Electrical Industry, which contributes to the Plan on behalf of Participants, upon determination by the Trustees that such participation is in the best interest of the Participants and Beneficiaries of the Plan. Related Organizations are:

- St. Paul Electrical Industry Administrative Service Corporation.
- Local Union 110, IBEW.
- St. Paul Federal Credit Union.
- St. Paul Chapter NECA.
- St. Paul Electrical J.A.T.C.

Reliable Evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocols used by the treating Facility or the protocol(s) of another Facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating Facility or by another Facility studying substantially the same, drug, device or medical treatment or procedure.

Residential Behavioral Health Treatment Facility means a Facility licensed under state law in the state in which it is located that provides treatment by or under the direction of a Doctor of medicine (M.D.) or osteopathy (D.O.) for mental health disorders, alcoholism, Substance Abuse or Substance Addiction. The Facility provides continuous, twenty-four (24)-hour supervision by a skilled staff who are directly supervised by health care professionals. Skilled nursing and medical care are available each day. A Residential Behavioral Health Treatment Facility does not, other than incidentally, provide educational or recreational Services as part of its treatment program. Treatment received at Skilled Nursing Facilities and Residential Behavioral Health Treatment Facilities are subject to the same levels of Plan benefits and coverage whether such treatment is related to Medical-Surgical conditions or Mental Health-Substance Abuse conditions.

Respite care means short-term Inpatient or home care provided to the patient when necessary to relieve family members or other persons caring for the patient.

Retiree means a person who has undergone Early Retirement or Normal Retirement.

Services means health care service, procedures, treatments, durable medical equipment, medical supplies, and prescription drugs.

Skilled Care means Services rendered in a Skilled Nursing Facility or in a Home Health Care setting that are Medically Necessary and provided by a licensed nurse or other licensed health care provider. A service shall not be considered Skilled Care merely because it is performed by, or under the direct supervision of, a licensed nurse. Services such as tracheotomy suctioning or ventilator monitoring that can be safely and effectively performed by a non-medical person (or self-administered) without direct supervision of a licensed nurse, shall not be regarded as Skilled Care, whether or not a licensed nurse actually provides the service. The unavailability of a competent person to provide a non-skilled service shall not make it Skilled Care when a licensed nurse provides the service. Only the Skilled Care component of combined Services that include non-Skilled Care are covered under the Plan.

Skilled Nursing Facility means a Medicare approved Facility that provides skilled transitional care, by or under the direction of a Doctor of Medicine (M.D.) or Osteopathy (D.O.), after a Hospital stay. A Skilled Nursing Facility provides twenty-four (24)-hour-a-day professional registered nursing (R.N.) Services. Treatment received at Skilled Nursing Facilities and residential treatment centers are subject to the same levels of Plan benefits and coverage whether such treatment is related to Medical-Surgical conditions or Mental Health-Substance Abuse conditions.

Spouse means Your legally married Spouse, regardless of gender. The Plan may require proof of a legal marriage.

Substance abuse and/or Addictions – Chemical Dependency means alcohol, drug dependence or other Addictions as defined in the most current editions of the International Classification of Diseases (ICD) and Diagnostic and Statistical Manual for Mental Disorders (DSM).

Surrogate pregnancy means when a woman becomes pregnant for the purpose of gestating and giving birth to a Child for others to raise. Pregnancy may have been the result of conventional means, artificial insemination or assisted reproductive technologies.

Telemedicine means telemedicine Services may also be referred to as televideo consultations or telehealth Services. These Services are interactive audio and video communications, permitting real-time communication between a distant site Physician or practitioner and the Participant, who is present and participating the in the televideo visit at a remote Facility.

Temporary Total Disability is where the Participant is unable to engage in the usual and customary duties of the Participant's own occupation due to bodily Injury or Illness.

Total Permanent Disability is a disability where the Participant is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than twelve (12) months, provided, however, that any of the following disabilities will not entitle a Participant to a Disability Benefit from this Plan:

- Disability that was contracted, suffered or occurred while the Participant was engaged in, or resulted from having engaged in, a felonious act or enterprise;
- Disability that was self-inflicted;
- Disability arising out of, or occurring during service in the armed forces of any country; or
- Disability that results in a Participant receiving other disability benefits or worker's compensation, benefits outside of the Electrical Industry.

You or Your means a person who is a Participant in this Plan as a result of working in Covered Employment.

Reciprocity

You may have Your Employer contributions forwarded to Your Home Fund through the IBEW National Reciprocity Agreement if You work in the industry away from the geographical location of Your local's Collective Bargaining Agreement.

All members of the International Brotherhood of Electrical Workers (IBEW) who have contributions made on their behalf to the Plan while working in the jurisdiction of Local Union 110 and are eligible for reciprocity under the terms of the IBEW National Reciprocity Agreement will have contributions forwarded to their Home Fund. You must register with the Electronic Reciprocal Transfer System (ERTS) in order to have contributions sent to Your Home Fund in conformity with that agreement.

Those members not eligible for reciprocal transfer under the terms of the IBEW National Reciprocity Agreement may establish eligibility by providing proof of permanent residence within the Local Union 110 jurisdiction and their intent and ability to continue working in the Local Union 110 jurisdiction.

EXHIBIT A – Initial Notice of COBRA Continuation Coverage Rights

St. Paul Electrical Workers' Health Plan
1330 Conway Street, Suite 130
St. Paul, MN 55106

INITIAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS
For The St. Paul Electrical Workers' Health Plan

**** CONTINUATION COVERAGE RIGHTS UNDER COBRA****

Introduction

You are receiving this notice because You have recently become covered under the St. Paul Electrical Workers' Health Plan (the "Plan"). The Plan provides a variety of benefits, including medical, dental, vision, life insurance and disability. This notice describes Your right to continue certain benefits under the Plan when You would otherwise lose health coverage. When certain events occur, You may elect to continue the Medical benefits portion of the Plan only.

This notice contains important information about Your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to You and other members of Your family who are covered under the Plan when You would otherwise lose Your group health coverage. **This notice generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You need to do to protect the right to receive it.** COBRA (and the description of COBRA coverage in this notice) applies only to the Medical Benefits offered in the Plan and not the other non-medical benefits. (The Plan may allow You to continue other non-medical benefits in the Plan through self-payments but that is not COBRA coverage.)

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 the plan generally doesn't accept late enrollees.

Although there is no right under COBRA to continue life insurance coverage, Minnesota state law requires that You and other members of Your family be allowed to elect to continue life insurance coverage for up to eighteen (18) months if coverage is lost due to termination of employment (for any reason other than gross misconduct) or reduction in hours of employment.

Address Changes

In order to protect Your family's rights, You should keep the St. Paul Electrical Workers' Health Plan Fund Office informed of any changes in the addresses of Yourself or Your family members. You should also keep a copy, for Your records, of any notices You provide to the Fund Office.

Contact Information for the Plans

Information about the Plans and COBRA continuation coverage can be obtained on request from the St. Paul Electrical Workers' Health Plan Fund Office. The Fund Office's contact information is as follows:

Wilson-McShane Corporation
1330 Conway Street, Suite 130
St. Paul, MN 55106
952-851-5949 (phone)
651-776-9973 (fax)

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified Beneficiary." You, Your Spouse, and Your dependent Children could become qualified Beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If You are an employee, You will become a qualified Beneficiary if You lose Your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than Your gross misconduct.

If You are the Spouse of an employee, You will become a qualified Beneficiary if You lose Your coverage under the Plan because any of the following qualifying events happens:

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from Your Spouse.

Your dependent Children will become qualified Beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The Child stops being eligible for coverage under the plan as a "dependent Child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified Beneficiaries only after the Fund Office has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Fund Office of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and Spouse or a dependent Child's losing eligibility for coverage as a dependent Child), You must notify the Fund Office within sixty (60) days after the qualifying event occurs. You must provide this notice to:

Wilson-McShane Corporation
1330 Conway Street, Suite 130
St. Paul, MN 55106
(952) 851-5949 (phone)
651-776-9973 (fax)

In the event of a divorce or legal separation, court documents need to be presented as proof of legal change.

If You fail to provide notice of a qualifying event in the appropriate timeframe, the Fund Office may deem such failure to be a waiver of COBRA coverage and may take all and any necessary action to enforce the Plan's rights.

How is COBRA Coverage Provided?

Once the Fund Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified Beneficiaries. Each qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their Children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for eighteen (18) months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a Beneficiary to receive a maximum of thirty-six (36) months of coverage.

There are also ways in which this eighteen (18)-month period of COBRA continuation coverage can be extended:

Disability extension of eighteen (18)-month period of continuation coverage

If You or anyone in Your family covered under the Plan is determined by the Social Security Administration to be disabled and You notify the Fund Office in a timely fashion, You and Your entire family may be entitled to receive up to an additional eleven (11) months of COBRA continuation coverage, for a total maximum of twenty-nine (29) months. The disability would have to have started at some time before the sixtieth (60^{th}) day of COBRA continuation coverage and must last at least until the end of the eighteen (18)-month period of continuation coverage.

Second qualifying event extension of eighteen (18)-month period of continuation coverage

If Your family experiences another qualifying event while receiving eighteen (18) months of COBRA continuation coverage, the Spouse and dependent Children in Your family can get up to eighteen (18) additional months of COBRA continuation coverage, for a maximum of thirty-six (36) months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the Spouse and any dependent Children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent Child stops being eligible under the Plan as a dependent Child, but only if the event would have caused the Spouse or dependent Child to lose coverage under the Plan had the first qualifying event not occurred. In all of these cases, You must make sure that the Fund Office is notified of the second qualifying event within sixty (60) days of the second qualifying event. This notice must be sent to:

Wilson-McShane Corporation
1330 Conway Street, Suite 130
St. Paul, MN 55106
(952) 851-5949 (phone)
651-776-9973 (fax)

Proper documentation will need to be presented at the time of the qualifying event such as a divorce decree, death certificate, etc.

Circumstances in Which Continuation Coverage May Be Cut Short

Your COBRA coverage will end before the end of the relevant maximum COBRA coverage period if any of several events occurs:

- The qualified Beneficiary becomes covered – after electing COBRA coverage – under another group health plan (as an employee or otherwise).
- The premium for Your continuation coverage is not paid by the due date;
- The Plan no longer provides any group health coverage to any employee;
- Coverage is extended due to disability, and during a twenty-nine (29)-month disability extension, there is a final determination that the qualified Beneficiary ceased to be disabled;
- After electing COBRA continuation coverage, a qualified Beneficiary becomes eligible for and enrolls in Medicare (Part A, Part B, or both);
- Any reason the Plan would terminate coverage of a Participant or Beneficiary who is not receiving continuation coverage (e.g., fraud).

Continuation Coverage for Military Leave

If You leave Your job to perform military service protected by the Uniformed Services Employment and Reemployment Rights Act, Your continuation coverage may last up to twenty-four (24) months.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for You and Your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the Fund Office listed above. 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** or call their toll free number, 1-866-444-3272. For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep Your Plan Informed of Address Changes

In order to protect Your family's rights, You should keep the Fund Office (which is the Plan Administrator) informed of any changes in the addresses of family members. You should also keep a copy, for Your records, of any notices You send to the Fund Office.

Plan Contact Information

Wilson-McShane Corporation
1330 Conway Street, Suite 130
St. Paul, MN 55106
952-851-5949 (phone)
651-776-9973 (fax)

EXHIBIT B – Notice of Privacy Practices

ST. PAUL ELECTRICAL WORKERS HEALTH PLAN - (The Plan)
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Health Programs Covered By This Notice

This Notice describes the practices of the group health programs (Medical, Dental and Vision plans) that are part of this Plan and will apply to You to the extent You participate in these programs. If You participate in other programs, You may receive additional notices.

Pledge Regarding Your Protected Health Information

This Notice explains how the Plan uses and discloses Your protected health information and the rights that You have with respect to accessing that information and keeping it confidential. "Protected health information" means information that individually identifies You, and relates to payment for Your health care, Your health or condition, or health care You receive, including demographic information. The Plan creates, receives and maintains eligibility and enrollment information, information about Your health care claims paid under the Plan, and other protected health information that is necessary to administer the Plan.

The Plan is required by law to maintain the privacy of Your protected health information and to provide this Notice to You. This Notice explains the Plan's legal duties and privacy practices, and Your rights regarding Your protected health information. The Plan is committed to protecting the privacy of Your protected health information by complying with all applicable federal and state laws.

While this Notice is in effect, the Plan must follow the privacy practices described. This Notice takes effect on the effective date shown below, and will remain in effect until it is replaced. The Plan reserves the right to change its privacy practices and the terms of this Notice at any time, provided that applicable law permits such changes. The Plan reserves the right to make such changes effective for all protected health information that the Plan maintains, including information created or received before the changes were made. The Plan will provide a revised copy of the Notice through the mail.

You may request a copy of the Plan's Notice of Privacy Practices at any time. For more information about the Plan's privacy practices, or for additional copies of this Notice, please contact the Plan using the information listed at the end of this Notice.

Uses and Disclosures of Your Protected Health Information

The following categories describe the different ways the Plan uses and discloses Your protected health information. Not every use or disclosure within a category is listed, but all uses and disclosures fall into one of the following categories:

- *For Treatment.* The Plan may disclose Your protected health information to a health Provider to assist them in providing You with medical treatment or Services including helping Providers to coordinate Your care. For example, a health care Provider, such as a Physician, nurse, or other person providing health Services to You, may request information in Your record that is related to Your treatment. We will convey this information to the health care Provider to assist them in determining what treatment You should receive. Health care Providers will also record actions taken by them in the course of Your treatment and note how You respond to the treatment.

- *For Payment.* The Plan may use and disclose Your protected health information to others for purposes of paying for treatment and Services that You receive. For example, a bill may be sent to You or this Plan. The information on the bill may contain information that identifies You, Your diagnosis, and treatment or supplies used in the course of treatment. The Plan will use this information to process the bill to determine if it is for a treatment covered under the Plan, to pay the bill, to negotiate with the health care Provider and to seek any coordination of coverage with another plan. The Plan may use and disclose protected health information to determine Your eligibility for Plan benefits, facilitating payment for treatment and health care Services You receive, determining benefit responsibility under the Plan, coordinating benefits with other plans, determining Medical Necessity, and so on. For example, the Plan may share protected health information with third party administrators hired to provide claims Services and other administrative Services to the Plan.

- *For Health Care Operations.* The Plan may use and disclose protected health information about You for operational purposes. The Plan may use and disclose protected health information for underwriting, premium rating and other activities relating to Plan coverage; submitting claims for stop-loss coverage; conducting or arranging for medical review, legal Services, audit Services, and fraud and abuse detection programs; and business planning, management and general administration. To the extent the Plan uses or discloses protected health information for underwriting purposes, under HIPAA the Plan is prohibited from using or disclosing protected health information that is Genetic Information of an individual for such purposes.

- *Benefits.* The Plan may use and disclose protected health information to tell You about or recommend possible treatment options or alternatives, or to tell You about health-related products or Services (or payment or coverage for such products or Services) that may be of interest to You. The Plan may use Your protected health information to contact You with information about benefits under the Plan, including certain communications about health plan networks, health plan changes, and value-added health plan-related products or Services. The Plan may communicate with You face-to-face regarding any benefits, products or Services. The Plan may use or disclose protected health information to distribute small promotional gifts.

- *Heath Plan Disclosure to Sponsors of Plan.* The Plan may disclose Your protected health information to the Plan Sponsors, Trustees, but only to permit the Trustees to perform Plan administration and fiduciary functions.

- *Required by Law.* The Plan may use and disclose information about You as required by law. For example, the Plan may disclose Your protected health information in response to a court or administrative order, subpoena, discovery request, or other lawful process, in accordance with specified procedural safeguards. Under certain circumstances, such as a court order, or court-issued warrant, subpoena or summons, or grand jury subpoena, the Plan may disclose Your protected health information to law enforcement officials. The Plan also may disclose limited protected health information to a law enforcement official concerning a suspect, fugitive, material witness, crime victim or missing person. The Plan may disclose protected health information about the victim of a crime (under limited circumstances); about a death the Plan believes may be the result of criminal conduct; to report a crime on the premises of the Plan; or, in an emergency, information relating to a crime not on the premises. If You are an inmate of a correctional institution, the Plan may disclose protected health information to the institution or to law enforcement.

- *Public Health.* Your protected health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, Injury, or disability, or for other health oversight activities. The Plan may disclose Your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

- *Decedents (Death, Organ/Tissue Donation).* Your protected health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes. The Plan may disclose protected health

information of a deceased person to a coroner, medical examiner, funeral director, or organ procurement organization, for certain limited purposes.

- *Research.* The Plan may use or disclose protected health information for research purposes, provided that the researcher follows certain procedures to protect Your privacy. To the extent it is required by state law, the Plan will obtain Your consent for a disclosure for research purposes.

- *Government Functions.* Specialized government functions such as protection of public officials or reporting to various branches of the armed Services may require use or disclosure of Your protected health information.

- *Workers Compensation.* Your protected health information may be used or disclosed in order to comply with laws and regulations related to workers compensation.

- *Plan Communications with Individuals Involved in Your Care (or Payment for Your Care).* In general, the Plan will communicate directly with You about Your claims and other Plan-related matters that involve Your protected health information. In some cases, however, it may be appropriate to communicate about these matters with other individuals involved in Your health care or payment for that care, such as Your family, relatives, or close personal friends (or anyone else, if You choose to designate them). If You agree, the Plan may disclose to these persons protected health information about You that is directly relevant to their involvement in these matters. The Plan may also make such disclosures to these persons if You are given the opportunity to object to the disclosures and do not do so, or if the Plan reasonably infers from the circumstances that You do not object to disclosure to these persons. In these circumstances, the Plan would not need to obtain Your written authorization. For example, if You are an employee and are attempting to resolve a claims dispute with the Plan, and You orally inform the Plan that Your Spouse will be calling the Plan for additional discussion of these issues, the Plan would be permitted to disclose protected health information directly relevant to that dispute to Your Spouse.

  The Plan also may use or disclose Your name, location and general condition (or death) to notify, or help to notify persons involved in Your care about Your situation. If You are incapacitated or in an emergency, the Plan may disclose Your protected health information to persons involved in Your care (or payment) if it determines that the disclosure is in Your best interest.

- *De-Identified Data*. The Plan may create a collection of information that can no longer be traced back to You (i.e., does not contain individually identifying information).

OTHER DISCLOSURES REQUIRE AUTHORIZATION: Other uses and disclosures of Your personal protected health information will be made only with Your written authorization. You may revoke Your authorization at any time by providing a written revocation to the Plan.

Specific Disclosures Which Require Authorization Under HIPAA

- *Uses and Disclosures You Specifically Authorize*. You may give the Plan written authorization to use Your protected health information or to disclose it to anyone for any purpose. If You give the Plan an authorization, You may revoke it in writing at any time. If You revoke Your permission, the Plan will stop using or disclosing Your protected health information in accordance with that authorization, except to the extent the Plan has already relied on it. Without Your written authorization, the Plan may not use or disclose Your protected health information for any reason except those described in this Notice.

- *Psychotherapy Notes*. The Plan must obtain an authorization for any use or disclosure of psychotherapy notes, except in limited circumstances as provided in 45 C.F.R. §164.508(a)(2).

- *Marketing.* The Plan must obtain an authorization for any use or disclosure of protected health information for marketing (as defined under HIPAA), except if the communication is in the form of a

face-to-face communication made by the Plan to an individual; or a promotional gift of nominal value provided by the Plan. If the marketing involves financial remuneration, as defined in paragraph (3) of the definition of marketing at 45 C.F.R. §164.501, to the Plan from a third party, the authorization must state that such remuneration is involved.

- *Sale of Protected Health Information*. Except in limited circumstances covered by the transition provisions in 45 C.F.R. §164.532, the Plan must obtain an authorization for any disclosure of protected health information which is a sale of protected health information, as defined in 45 C.F.R. §164.501. Such authorization must state that the disclosure will result in remuneration to the covered entity.

Your Rights

- *Access.* You have the right to look at or get copies of protected health information maintained by the Plan that may be used to make decisions about Your Plan eligibility and benefits, with limited exceptions. The Plan reserves the right to require You to make this request in writing. If You request copies, You may be charged a fee to cover the costs of copying, mailing, and other supplies. If You prefer, the Plan will prepare a summary or an explanation of Your protected health information for a fee. The Plan may deny Your request in very limited circumstances. If the Plan denies Your request, You may be entitled to a review of that denial. You will be told how to obtain a review. The Plan will abide by the outcome of that review.

- *Amendment.* If You feel that Your protected health information is incorrect or incomplete, You have the right to request that the Plan amend it. The Plan reserves the right to require this request be in writing, including a reason to support Your request. The Plan may deny Your request if the Plan did not create the information You want amended or for certain other reasons. If the Plan denies Your request, the Plan will provide You a written explanation and the process to be followed for any additional action.

- *Accounting of Disclosures.* You have the right to receive a list of disclosures the Plan has made of Your protected health information. This right does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. Your request for the accounting must be in writing. You are entitled to such an accounting for the six (6) years prior to Your request. The Plan will provide You with the date on which it made a disclosure, the name of the person or entity to whom it disclosed Your protected health information, a description of the protected health information it disclosed, the reason for the disclosure, and certain other information. If You request this list more than once in a twelve (12)-month period, the Plan may charge You a reasonable, cost-based fee for responding to these additional requests. You will be notified of the cost involved and be given the opportunity to withdraw or change Your request before any costs are incurred.

- *Restriction Requests.* You have the right to request that the Plan place additional restrictions on its use or disclosure of Your protected health information for treatment, payment, or health care operations. The Plan is not required to agree to these restrictions, but if it does, the Plan will abide by its agreement (except in a medical emergency). A covered entity must agree to the request of an individual to restrict disclosure of protected health information about the individual to a health plan if: (A) The disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (B) The protected health information pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid the covered entity in full. Any such agreement by the Plan must be in writing signed by a person authorized to make such an agreement on our behalf; without this written agreement, the Plan will not be bound by the requested restrictions. Please use the contact information at the end of this Notice to get more information about how to make such a request.

- *Confidential Communication.* You have the right to request that the Plan communicate with You about Your protected health information by alternative means or to an alternative location. For example, You may ask that the Plan contact You only at work or by mail. You must make Your request in writing

and must specify how or where You wish to be contacted. Your request must state that the information could endanger You if it is not communicated in confidence as You request. The Plan will accommodate all reasonable requests. Please use the contact information at the end of this Notice to get more information about how to make such a request.

- *Copy of this Notice.* You are entitled to receive a printed (paper) copy of this Notice at any time. Please contact the Plan using the information listed at the end of this Notice to obtain a copy of this Notice in printed form.

Obligations of the Plan

The Plan is required to:

- Maintain the privacy of protected health information;
- Make available to You this Notice which describes the Plan's legal duties and privacy practices with respect to Your protected health information;
- Abide by the terms of this Notice;
- Notify You if we are unable to agree to a requested restriction on how Your information is used or disclosed;
- Notify You of any breach of Your unsecured protected health information;
- Accommodate reasonable requests You may make to communicate protected health information by alternative means or at alternative locations; and
- Obtain Your written authorization to use or disclose Your protected health information for reasons other than those listed above and permitted under law.

The Plan reserves the right to change its information practices and to make the new provisions effective for all protected health information it maintains. Revised Notices will be mailed.

Questions and Complaints

If You want more information about the Plan's privacy practices, have questions or concerns, or believe that the Plan may have violated Your privacy rights, please contact the Plan using the following information:

Martin C. Lasley
Wilson-McShane Corporation
1330 Conway Street, Suite 130
St. Paul, MN 55106
952-851-5949 (phone)

You also may file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

The Plan supports Your right to protect the privacy of Your health information. The Plan will not retaliate in any way if You choose to file a complaint with the Plan or with the U.S. Department of Health and Human Services.

Conclusion

Uses and disclosures of Your protected health information by the Plan are regulated by the federal HIPAA law. This Notice attempts to summarize the Privacy Regulations. The Privacy Regulations will supersede any discrepancy between the information in this Notice and the regulations.

EXHIBIT C – Annual Notice of Language Access Services

This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.

Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al 1-855-903-2583. Para TTY, llame al 711.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaa caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

နမ့်ကတိၤကညီကျိာ်ဒီး, တၢ်ကဟ့ဉ်နၤကျိာ်တၢ်မၤစၢၤကလိတဖဉ်နွဉ်လီၤ. ကိး 1-866-251-6744 လ၊ TTYအဂီ, ကိး 711 တက့ၢ်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهاتف النصي اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta'e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

አማርኛ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ አገልግሎት እርዳ አለሎት። በ 1-855-315-4030 ይደውሉ ለ TTY በ 711።

한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ສຳລັບ. TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមែន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Kojį éí béésh bee hodíílnih áǫįęęǫíǫąǫęįą. TTY biniiyégo éí íáájį' béésh bee hodíílnih.

Notice of Nondiscrimination Practices

The Claims Administrator complies with the applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or gender. The Claims Administrator does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

The Claims Administrator provides resources to access information in alternative formats and languages.

- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with us.

- Language services, such as qualified interpreters and information written in other languages, are available free of charge to people whose primary language is not English.

If you need these services, please contact the Claims Administrator, Wilson-McShane Corporation, at 952-835-3035 or 800-247-0401.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights

- electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

- by phone at: 1-800-368-1019 or 1-800-537-7697 (TDD)

- or by mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue SW
  Room 509F
  HHH Building
  Washington, DC 20201

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Coverage of Health Care Services on the Basis of Gender

Federal law prohibits denying or limiting health services, that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that the individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available. Eligible, covered services must be medically necessary, and remain subject to any requirements outlined in the Claims Administrator's medical policy and/or federal law.

EXHIBIT D – Policy For Medical Necessity Review of Outpatient Drug Testing

This Exhibit D outlines Wilson-McShane and the Plan's policy for identifying and routing medical claims for outpatient drug testing related to substance use disorders for medical necessity review by an outside party. The intent of this procedure is to ensure parity of benefits being applied to mental health and substance use claims.

Policy

Any outpatient drug testing claims with a diagnosis, at any level (primary, secondary, tertiary, etc.), of substance use disorder will be processed as follows:

1. The claims examiner will review any information, including clinical edits, suspensions, medical policy, or corresponding medical records, associated with the claim or a specific claim line to determine whether a medical necessity review is required.

    a. If medical necessity review is required, the claims examiner will, following the procedures specific to the system/network on which the claim is handled:

        i. Deny or pend the claim and request any necessary records from the submitting provider.
        ii. The examiner will document the reason for the denial and the request for records.

    b. If medical necessity review is not required, the claims examiner will apply the Plan's participant cost share (including coinsurance, deductible, and co-payments) as well as the appropriate network negotiated rate and/or usual and customary pricing) and approve the claim or claim line.

2. If additional medical records are required, the claims examiner will, following the procedures specific to the system/network on which the claim is handled, document the request for additional records in the system log, and including the following information:

    a. Claim Number
    b. Date of Request
    c. Name of Provider
    d. Clinical edit, suspension, or medical policy reference on which the request for records is based
    e. Claims examiner name

3. Upon receipt of the requested medical records, the claims examiner will, following the procedures specific to the system/network on which the claim is handled, document the receipt of the requested documents in the system log, and include the following information:

    a. Claim Number
    b. Date of Request
    c. Provider
    d. Clinical edit, suspension, or medical policy reference on which the request for review of medical necessity is based
    e. Claim examiner name
    f. Description of received documents

4. The claims examiner will, following the procedures specific to the system/network on which the claim is handled, send the request for review of medical necessity to the appropriate outside reviewing entity for the Plan. The claims examiner will document the request for additional records in the system log, and including the following information:

    a. Claim Number
    b. Date of Request
    c. Provider
    d. Clinical edit, suspension, or medical policy reference on which the request for review of medical necessity is based
    e. Name of outside medical review entity

5. Upon receipt of the completed review for medical necessity, the claims examiner will, following the procedures specific to the system/network on which the claim is handled, document the reviewer's determination, and process the claim consistent with such determination.

    a. If the claim is determined to be medically necessary, the claims examiner will:

        i. Apply the Plan's participant cost share (including coinsurance, deductible, and co-payments, as well as appropriate network negotiated rate and/or usual and customary pricing) and approve the claim or claim line.
        ii. Document receipt of the medical necessity determination and approval of the claim in the system log.
        iii. Save the medical necessity determination document in the system or record appropriate notes.

    b. If the claim is determined to not be medically necessary, the claims examiner will:

        i. Deny the claim, include the Plan's required medical necessity adverse benefit determination and appeal language.
        ii. Document receipt of the medical necessity determination and denial in the system log.
        iii. Save the medical necessity determination document in the system or record appropriate notes.