SUMMARY PLAN DESCRIPTION
FOR
THE RETIREMENT MEDICAL FUNDING PLAN

FOR THE ST. PAUL ELECTRICAL WORKERS

(DATED OCTOBER 1, 2016)

October 2016

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I. INTRODUCTION TO YOUR PLAN

The Trustees restated the Trust Agreement governing your Retirement Medical Funding Plan (formerly known as the Reserve Trust) (the "Plan") as of October 1, 2009. They are further restating the Plan's Summary Plan Description effective October 1, 2016. The Plan is for the exclusive benefit of eligible employees (and their surviving spouses) engaged in Covered Employment in the electrical industry for whom contributions are made to this Plan.

The purpose of this Plan is to provide funding for retiree health benefits, disability health benefits and surviving spouse health benefits. The Trustees will provide a monthly allowance to eligible participants to be applied against the monthly cost of providing health coverage under the St. Paul Electrical Workers Health Plan or to reimburse eligible participants for the cost of another employer-sponsored health plan.

This Summary Plan Description is a brief description of your plan and your rights, obligations, and benefits under that Plan. However, the Trust Agreement for the Plan and the official minutes of the Board of Trustees constitute the final and binding rules and regulations governing the operation of the Trust. Additional information is available at the Plan office. The only people authorized to answer questions concerning this Plan are the Board of Trustees and the Staff at the Plan office. If you have questions regarding these Plans, contact the Plan office at (651) 776-IBEW (4239) or toll free 1-888-439-4239 and select option 4.

II. GENERAL INFORMATION ABOUT YOUR PLAN

There is certain general information which you may need to know about your Plan. This information has been summarized for you in this section.

A. General Plan Information

Retirement Medical Funding Plan for St. Paul Electrical Workers is the name of your Plan. The Trust Agreement for the Plan was most recently restated on October 1, 2009.

St. Paul Electrical Construction Workers Reserve Trust was the original Plan name.

The Employer Identification Number is 41-1334004.

The Plan Identification Number is 504.

Your Plan records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on October 1 and ends on September 30.

The contributions made to your plan by your Employer (or by you under a participation agreement) shall be held and invested by the Trustees of your Plan.

The Trust is governed by the laws of the State of Minnesota. This Plan is governed by federal laws relating to employee welfare plans.

B. Plan Sponsors

The sponsors of your Plan are the St. Paul Chapter of the National Electrical Contractors Association and Local 110 of the International Brotherhood of Electrical Workers, AFL-CIO.

C. Plan Administrator Information

The name, address, and business telephone number of your Plan Administrator are:

St. Paul Electrical Industry
Administrative Service Corporation
1330 Conway Street, #130
St. Paul, Minnesota 55106
(651) 776-IBEW (4239) Option 4

Your Plan Administrator keeps the records for the plan and is responsible for the administration of the Plan. Your Plan Administrator will also answer any questions you may have about your Plan.

D. Plan Trustee Information

The names of your Plan Trustees are:

Union Trustees	**Employer Trustees**
James C. Schult	Luke M. Kuhl
Jamie M. McNamara	J.T. Pedersen
Edward P. Nelson	Peter B. Bourland

Your Plan Trustees have been designated to hold and invest Plan assets for the benefit of you and other Plan participants.

E. Service of Legal Process

The name and address of your Plan's agent for service of legal process is:

Ronald G. Ethier, CEBS, Administrator
St. Paul Electrical Industry
Administrative Service Corporation
1330 Conway Street, #130
St. Paul, Minnesota 55106

Service of legal process may also be made upon any of the Trustees.

III. PARTICIPATION IN YOUR PLAN

A. General Eligibility Requirements

Before you become a member or a "participant" in the Plan, there are certain eligibility and participation rules you must meet. These rules are explained in this section.

1. You must have worked in Covered Employment for which your Employer has agreed in a collective bargaining agreement or in an agreement with the Trustees to contribute to this Plan on your behalf. In addition, you may have worked in Covered Employment for which you have agreed in an agreement with the Trustees to contribute to the Plan on your own behalf.

2. You must have attained age 55 and earned at least 10 Service Credits.

3. Retirement must occur on or after January 1, 2003. If you received a pension check prior to January 1, 2003, you will remain on the program in effect at the time of your retirement and not be eligible for the new benefit program.

4. You must be receiving a pension check from an IBEW/NECA-sponsored defined benefit pension plan, provided, however, that this requirement is waived for Alumni Non-bargained Employees retiring from a management position with a Related Organization prior to age 65. If you work in Prohibited Employment as defined in the pension plan rules, whether during early or normal retirement, your eligibility for and participation in retiree funding health benefits will be suspended until such Prohibited Employment ceases.

5. You must be eligible for and covered by the St. Paul Electrical Workers Health Plan (Health Plan) at the time of retirement for 60 consecutive months' immediately preceding retirement. Eligibility maintained by disability hours, self-pay contributions (including COBRA), or other Trustee-approved methods for extending eligibility will be recognized for this purpose. If there has

been an interruption in the 60 consecutive month period, but if your period of coverage following the interruption is equal to or greater than the period of interruption in participation in the Health Plan and if your pre-interruption and post-interruption periods of coverage total 60 months of coverage or more, you are deemed to satisfy this eligibility requirement. If the Participant has experienced an interruption in participation in the Health Plan as a result of unemployment through no fault of Participant and there was no work available in Participant's job classification, such unemployment shall count toward satisfying the 60 month time frame herein. In establishing such a period of unemployment, Participant must provide information to the Trustees establishing that the Participant has not left the electrical industry, that the Participant remained properly registered and available for employment, and that the Participant did not refuse work in accordance with prevailing administrative procedures for referral established by the Union.

IV. SERVICE CREDITS UNDER THE PLAN

1. Past Service Credits

For past service credits, Participants will be provided with a service credit which corresponds to the cumulative hours in Covered Employment as an IBEW Local 110 member, under the Pension Plan through September 30, 2002, divided by 1,700 and rounded down to the nearest .1 credit. Total past service credits may not exceed the total number of years in Covered Employment.

As of January 1, 2002, certain Alumni Non-Bargained Employees were allowed to enter the Plan. These employees shall be given a window period to elect to enter into an agreement with Trustees to contribute amounts for past service credit for years of Covered Employment not previously funded under a collective bargaining agreement. Contributions for the past service credit shall be the amount charged in the years in question for participation in this Plan plus a reasonable interest rate established by the Trustees. The agreement between the participant and the Trustees must be entered into on or before September 30, 2004.

2. Future Service Credits

For future service credits on and after October 1, 2002, Participants earn .1 credits for every 170 hours worked to a maximum of 1.0 credit at 1700 hours. Future credits will be based only on actual hours of contribution made to the Plan on your behalf, whether paid by your employer or you as an Alumni Non-Bargained Employee.

On or after January 1, 2002, certain Alumni Non-Bargained Employees were allowed to enter the Plan. Alumni Non-Bargained Employees are employees who were employed under a collective bargaining agreement to which this alumni rule applies in the discretion of the Trustees and who satisfy the eligibility requirements in Article III of this Summary Plan Description. Contact the Plan office for more information regarding the so-called Alumni Rule.

3. Total Service Credits

Total service credits are equal to the sum of past service credits and future service credits, limited to a maximum of 42 credits (71,400 hours).

V. BENEFITS UNDER YOUR PLAN

The benefit under this Plan is receiving a monthly contribution allowance which is applied to the monthly cost of providing health coverage under the St. Paul Electrical Workers Health Plan or health coverage under another employer-sponsored group health plan. The monthly contribution allowance provided is defined below for each qualifying event.

If the contribution allowance is used to pay for or obtain reimbursement for payment for coverage under another employer-sponsored group health plan other than the St. Paul Electrical Workers Health Plan, the participant must provide information regarding the other health plan within six (6) months of incurring the expense or invoice and must attest that the participant is covered by the plan: (A) In the case of direct payment to another health plan, the Participant must advise the Plan Administrator where payments to such health plan are to be made. (B) In the case of obtaining reimbursement for payment for premiums to another health plan, the Participant must provide substantiation of the health plan expense to the Plan Administrator as required by the Plan Administrator, including but not limited to, a copy of the health plan invoice and a copy of payment to the health plan. The Plan Administrator will then remit the applicable contribution allowance either: (1) directly to the other health plan and provide payment information to the Participant, or (2) by check made payable directly to Participant. This Plan will not pay any late fees or interest charges assessed by a health plan.

A. Accrued Contribution Allowance

The base calculation for determining the benefit under this Plan is your Accrued Contribution Allowance. Your Accrued Contribution Allowance is calculated by multiplying the applicable Accrual Rate by his or her service credits to a maximum of 42 credits. The applicable Accrual Rate is a percentage of the applicable retiree contribution rate charged by the Board of Trustees of the Health Plan and is determined according to the following table:

For Coverage on and after October 1, 2003:
(Calculation for Full Accrued Contribution Allowance)

Accrual Rate Contribution Allowance Prior to Medicare Eligibility	Accrual Rate Contribution Allowance After Medicare Eligibility
2.5% per service credit for first 32 service credits	1.75% per service credit for first 32 service credits

Plus 1% per service credit for next 10 service credits	Plus 1% per service credit for next 10 service credits

B. Benefits for Each Qualifying Event

1. Retiree Contribution Allowance – Normal Retirement (age 65 and older)

Eligibility: Retirement at Age 65.

Amount. Full Accrued Contribution Allowance.

2. Retiree Contribution Allowance – Early Retirement (ages 58 – 64)

Eligibility: Retirement at or after age 58 with at least 10 Service Credits.

Amount: Full Accrued Contribution Allowance.

3. Retiree Contribution Allowance – Early Retirement (ages 55 – 57)

Eligibility: Retirement at or after age 55 with at least 10 Service Credits.

Amount:

Prior to age 58:	No contribution allowance. Retiree pays full cost of coverage.
At or after age 58:	Full Accrued Contribution Allowance.

4. Contribution Allowance Upon Disability

Availability: For participants who become totally and permanently disabled on or after January 1, 2003.

Eligibility. Participant must be totally and permanently disabled, as defined under the Pension Plan; and Participant must have at least 10 Service Credits.

Amount. Accrued Contribution Allowance calculated using the greater of Participant's actual number of Service Credits or 20.

The Disabled Participant Contribution Allowance becomes available immediately after all other Health Plan disability benefits cease.

5. Surviving Spouse Contribution – Pre-Retirement Death

Availability: For surviving spouses of participants who die on or after January 1, 2003 and prior to retirement.

Eligibility: Participant must have earned a total of 10 Service Credits and dies before becoming eligible for the retiree Contribution Allowance or the Disabled Participant Contribution Allowance, the surviving spouse becomes eligible for the Surviving Spouse Contribution Allowance.

Amount: The amount of the Surviving Spouse Contribution Allowance is determined in the same manner as the Retiree Contribution Allowance. It becomes available on the first day of the month following the later of the date of death or the participant's 58th birthday; the surviving spouse shall pay the active self-pay rate until such time. Coverage may continue until the surviving spouse dies, remarries, or is covered by another group health plan.

6. Surviving Spouse Contribution – Post-Retirement Death

Availability: For surviving spouses of participants who were retired or disabled at the time of death and were covered by the Plan.

Eligibility: The surviving spouse is immediately eligible to continue coverage under the Plan until the surviving spouse dies, remarries or becomes covered by another group health plan.

Amount: Same Contribution Allowance of the deceased participant.

VI. MISCELLANEOUS PROVISIONS

A. Continuation of Coverage If Not Eligible as a Retiree, Disabled Participant or Surviving Spouse.

If you do not meet the eligibility requirements for an RMFP contribution allowance as a retiree, disabled participant, or surviving spouse as described in this summary, you may be able to continue health plan coverage by using the health plan's special continuation rules or the continuation rules of the Federal law known as COBRA. In the case of the St. Paul Electrical Workers Health Plan, please see the Plan booklet for an explanation of those rules. In the case of another employer-sponsored health plan

other than the St. Paul Electrical Workers Health Plan, please refer to that health plan's terms and conditions.

B. Retiree Health Benefits and Other Applicable Terms and Condition

The provisions described here relate only to the eligibility requirements for and the calculation of the Monthly Contribution Allowances and do not affect the health and welfare benefits provided to retirees, surviving spouses and disabled participants under the St. Paul Electrical Workers Health Plan or other plan providing health coverage. For those benefits and other terms and conditions of coverage see your health plan booklet (or benefits description of the other employer-sponsored plan providing health coverage) and subsequent notices of material modifications.

C. Trustees Rights and Powers

While the Board of Trustees of the Plan currently intend to continue the benefits provided by this Retirement Medical Funding Plan, the Board of Trustees reserves the right to amend or modify the Plan, in whole or in part, at any time, for any reason, including retroactive amendments if necessary or appropriate to meet the requirements of the Internal Revenue Code or ERISA. The authority to make any such changes to the Plan rests with the Board of Trustees. Any such amendment or modification of the Plan shall be made by a resolution adopted by the Board of Trustees. To the full extent permitted by law, the Trustees shall have exclusive authority and discretion to interpret or construe any term or provision in the Plan, and to decide any matter relating to Plan administration, including, but not limited to, the following:

1. Determining whether an individual is eligible for any benefits under the Plan;

2. Determining the amount of benefits, if any, an individual is entitled to under the Plan;

3. Interpreting all of the provisions of the Plan;

4. Interpreting all the terms used in the Plan; and

5. Determining questions of fact.

The Trustees' exercise of discretionary authority shall be binding upon any individual claiming benefits under the Plan, including but not limited to, the employee, eligible dependents, the employee's estate, and any service provider, and shall not be overturned or set aside by any court of law unless found to be arbitrary and capricious. The Board of Trustees has delegated the duty to determine eligibility for benefits and to

construe the provisions of the Plan to the Administrator. Benefits under this plan will be paid only if the Administrator decides in his discretion that the applicant is entitled to them. As a result, no statements made by the Board of Trustees, or any of its officers, directors, employees, or agents relating to eligibility of benefits or construing Plan terms shall be binding on the Plan. Plan Participants may not rely upon such statements by the Board of Trustees, its officers, directors, employees, or agents in making a claim for benefits. In addition no statements by the Board of Trustees, its officers, directors, employees, or agents will void any benefits due to a Plan Participant under the terms of the Plan. Any amendment to this Plan may be effected by a written resolution adopted by the Board of Trustees. Any amendment shall be filed with this Plan Document. The Board of Trustees will communicate any adopted changes to the Participants.

VII. CLAIMS BY PARTICIPANTS AND BENEFICIARIES

You or your beneficiaries may make a request for any Plan benefits that you may be entitled to get. Any such request must be made in writing. It should be made to the Plan Administrator. (See the Article in this Summary entitled "GENERAL INFORMATION ABOUT THE PLAN.")

Your request for Plan benefits shall be considered a claim for Plan benefits. It will be subject to a full and fair review. If your claim is denied, the Plan Administrator shall furnish you with a written notice of this denial. This written notice must be provided to you within a reasonable period of time (generally 90 days for all claims except disability claims; for disability claims notice shall be provided within 45 days) after the Plan Administrator receives your claim. The written notice must contain the following information.

1. The specific reason or reasons for the denial;

2. Specific reference to those Plan provisions on which the denial is based.

3. A description of any additional information or material necessary to correct your claim and an explanation of why the material or information is needed; and

4. Appropriate information as to the steps to be taken if you or your beneficiary wishes to submit your claim for review.

If adequate notice of the denial of a claim is not furnished to you within a reasonable period of time, you may regard your claim as being denied. You will then be permitted to proceed to the review stage described in the following paragraphs.

If your claim has been denied, and you wish to submit your claim for review, you must follow the Claims Review Procedure.

Your request for benefits and any subsequent review of a denial of benefits may be conducted through an authorized representative. If you authorize a representative to represent you, such authorization must be in writing and may be revoked in writing at any time. If an authorized representative is designated, all communications during the claims procedure may be directed to the authorized representative.

A. The Claims Review Procedure

1. All Benefits Except Disability Benefits

a. Upon the denial of your claim for benefits, you may file your claim for review, in writing, with the Plan Administrator. The form for this claim for review is available from the Employer or the Plan Administrator. The Trustees shall review the denial of your claim.

b. YOU MUST FILE THE CLAIM FOR REVIEW NO LATER THAN 60 DAYS AFTER YOU HAVE RECEIVED WRITTEN NOTIFICATION OF THE DENIAL OF YOUR CLAIM FOR BENEFITS.

c. You may review all pertinent documents relating to the denial of your claim and submit any issues and comments, in writing, to the Trustees.

d. Your claim for review will be given a full and fair review by the Trustees. If your claim is denied, the Trustees must provide you with written notice of this denial within 60 days after the Plan Administrator's receipt of your written claim for review. There may be times when this 60 day period may be extended. This extension may only be made, however, where there are special circumstances which are communicated to you in writing within the 60 day period. If there is an extension, a decision shall be made as soon as possible, but at least by 120 days after the Plan Administrator receives your claim for review.

e. The Trustees may, in their discretion, hold one or more hearings on a request for a review of a denied claim, provided, however, that the claims procedure shall not in any way be construed to require more than two appeals of an adverse benefit determination prior to bringing a civil action under section 502(a) of ERISA.

f. The Trustees' decision on your claim for review will be stated to you in writing. The statement will include specific references to the Plan provisions on which the decision was based.

g. If the Trustee's decision is not furnished to you within the time limitations described above, that is the same as a denial of your claim on review.

h. If benefits are provided or administered by an insurance company, insurance service, or other similar organizations which is subject to regulations under the insurance laws, the claims procedure relating to these benefits may provide for review. If so, that company, service, or organization shall be the entity to which claims are addressed. If you have any questions regarding the proper person or entity to address claims, you should ask the Plan Administrator.

2. Claims Review Procedure - Disability Claims.

If an appeal or review involves a claim for Disability Benefits under this Plan, the Claimant's right to review of such a claim will generally follow the process described above, with the following revisions and requirements:

a. You have at least 180 days following receipt of a notification that you claim for Disability Benefits has been denied in whole or in part.

b. If the claim for Disability Benefits was denied in whole or in part based on a medical judgment, the Trustees shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional who is engaged for the purpose of consultation under this paragraph shall be an individual who is neither an individual consulted in connection with the adverse benefit determination, nor the subordinate of any such individual.

c. You shall be provided the identification of the medical or vocational experts whose advice was obtained on behalf of the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

VIII. STATEMENT OF ERISA RIGHTS

A. Explanation of Your ERISA Rights

As a participant in this Plan you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974, also called ERISA. ERISA provides that all Plan participants shall be entitled to:

1. Examine, without charge, all Plan documents, including:

a. All documents governing the Plan;

b. Insurance contracts, if any;

2. Collective bargaining agreements; and

3. Copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

This examination may take place at the Plan Administrator's office and at other specified employment locations of the Employer. (See the Article in this Summary entitled "GENERAL INFORMATION ABOUT THE PLAN");

4. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

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

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the 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 pension benefit or exercising your rights under ERISA.

If your claim for a retirement benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider your claim. (See the Article in this Summary entitled "CLAIMS BY PARTICIPANTS AND BENEFICIARIES.")

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan

Administrator to provide the materials and pay you up to $110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suite in federal court. If the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

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 Area Office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.