Heat & Frost Insulators Local 34
Health & Welfare Plan

Effective April 1, 2022

SPD-900.4-MNSIEMP-34500-22

April 1, 2022

TO ALL PLAN PARTICIPANTS:

The information contained in this booklet is a summary of your Health and Welfare Plan and is effective April 1, 2022. The goal of this Plan is to protect you and your family from the high costs of sickness and disability.

The booklet serves as both the master plan document and the summary plan description and replaces all prior versions of those documents.

The benefits provided under the Plan shall not be considered "vested benefits" and the Trustees have the full authority to increase, reduce, or eliminate benefits, and to alter or revise eligibility rules or other provisions of the Plan at any time.

Plan Name

The Plan's name is the "Heat and Frost Insulators Local 34 Health & Welfare Plan."

We ask your cooperation in making this Plan successful. It is your Plan, and your assistance in controlling costs will help ensure continued security for you and your family. One of the easiest ways of controlling costs is by using doctors and hospitals who are members of the Preferred Provider Network.

Medical Preferred Provider Network

The Plan is part of a preferred provider network arrangement with HealthPartners. The Plan provides Network Benefits and Non-Network Benefits from which you may choose to receive Covered Services**.** Coverage may vary according to your network or provider selection. The provisions of this summary contain information you need to know to obtain Covered Services. All medical claims will be paid by HealthPartners for the Plan.

Prescription Drug Benefit Network

The Plan provides for a prescription drug benefit which is administered by ProAct. ProAct provides a formulary of covered brand name, generic and specialty prescription drugs. The prescription drug program provides for a comprehensive prescription drug benefit.

Delta Dental Network

The Plan has also entered into a preferred provider arrangement with Delta Dental of Minnesota. Delta Dental offers Plan participants its network of dentists who will provide quality dental care to you and your family. Those dentists have been allowed to become part of the network in exchange for charging lower prices for the services they provide. As a result, when you receive services from a network member, your coinsurance will likely be less. You may request a list of network members from the Union or Plan Administrator, or you can ask your dentist if he or she is a network provider.

As with the medical benefits network, you have the choice to use any provider you wish, whether that provider is in or out of the network.

If you visit a non-network dentist, you must pay the bill and submit a claim for reimbursement to the Plan Administrator.

Employee Assistance Program

(For resolution of alcoholism, chemical dependency, mental and nervous disorders, and other life issues)

The Plan provides an Employee Assistance Program through HealthPartners. HealthPartners will confidentially assess issues you or your family are facing, provide counseling to resolve those issues, and even refer you to others who can help you with those issues.

HealthPartners EAP services are covered under the Plan and are available to you twenty-four hours a day. **Of course, you have to take the first step and call HealthPartners for help.** The Trustees urge you to do that, before a small problem becomes a big one. You may contact HealthPartners at 1-866-326-7194 or visit their web site at http://www.healthpartners.com.

Health Reimbursement Account

The Plan provides a Health Reimbursement Account which allows you to be reimbursed for out-of-pocket medical expenses. This benefit is administered by HealthPartners. Contributions are made to the Health Reimbursement Account for each hour you work. You can send your receipts and any other required documentation to HealthPartners and be reimbursed up to the balance available in your account.

Please read this booklet carefully and keep it for future reference. If, after reviewing this booklet you have questions, we urge you to contact the Administration Office.

Sincerely,

The Board of Trustees

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DEFINITIONS

When used in this booklet, words and phrases shall have the following meanings unless a different meaning is plainly required by the context.

Admission: This is the medically necessary admission to an inpatient facility for the acute care of illness or injury.

Authorized Representative: This is a person appointed by you to act on your behalf in connection with an initial claim, an appeal of an adverse benefit determination, or both. To designate an authorized representative, you must complete and sign the "Appointment of Authorized Representative" form and return it to the Plan Manager. You should specify on the form the extent of the authorized representative's authority. This form is available by logging on to your "*my*HealthPartners" account at healthpartners.com.

Benefit Year: January 1 through December 31 of each year.

Biosimilar Drugs: A prescription drug, approved by the Food and Drug Administration (FDA), that the FDA has determined is biosimilar to and interchangeable with a biological brand name drug. Biosimilar drugs are not considered generic drugs and are not covered under the generic drug benefit.

CareLine℠ Service: This is a 24-hour telephone service which employs a staff of registered nurses who are available by phone to assist Covered Persons in assessing their need for medical care, and to coordinate after-hours care, as covered under the Plan.

Clinically Accepted Medical Services: These are techniques or services that have been determined to be effective for general use, based on risk and medical implications. Some clinically accepted medical services are approved only for limited use, under specific circumstances, as more fully described in this SPD.

Coinsurance, Co-payment or Co-pay: The amount that the patient pays for specified services each time the service is rendered.

Cosmetic Surgery: This is surgery to improve or change appearance (other than reconstructive surgery), which is not necessary to treat a related illness or injury.

Convenience Clinic: This is a clinic that offers a limited set of services and does not require an appointment.

Covered Dependent: This is the eligible dependent enrolled in the Plan.

Covered Employee: This is the eligible employee enrolled in the Plan.

Covered Percentage: The percentage of the eligible expenses which is covered by the Plan. The Covered Percentage is stated on the applicable Schedule of Benefits.

Covered Person: This is the eligible and enrolled employee and each of his or her eligible and enrolled dependents covered for benefits under the Plan. When used in this SPD, "you" or "your" has the same meaning as Covered Person.

Covered Service: This is a specific medical or dental service or item, which is medically necessary or dentally necessary and covered by the Plan, as described in this SPD.

Custodial Care: This is a supportive service focusing on activities of daily life that do not require the skills of qualified technical or professional personnel, including, but not limited to, bathing, dressing and feeding.

Deductible: The amount stated in the applicable Schedule of Benefits which is applicable to you and each eligible dependent in each benefit year for covered expenses incurred by that person. After the Deductible amount is satisfied, the covered percentage for eligible expenses will be paid. See the definition of Deductible in the Medical Benefits section for additional information.

Dentist: A duly licensed doctor of dental surgery or dental medicine, lawfully performing a dental service in accordance with governmental licensing privileges and limitations.

Dependent or Eligible Dependent: Dependent or Eligible Dependent: The employee's legal spouse and the employee's dependent children from birth to the end of the month in which they attain age 26. Dependent children include natural or legally adopted children, children for whom the employee or employee's spouse is the legal guardian and stepchildren of the employee.

An alternate recipient under a Qualified Medical Child Support Order is considered an Eligible Dependent. A Qualified Medical Child Support Order (QMCSO) is a judgment, decree, or order (including approval of a settlement agreement) issued by a court of law or state administrative agency empowered to issue such document, that either (a) provides for child support with respect to a child of a participant under the Plan or provides for health benefit coverage to such a child made pursuant to state domestic relations law, and relates to benefits under the Plan, or (b) is made pursuant to a law relating to medical child support with respect to the Plan (described in § 1396g of Title 42 of U.S. Code). The Plan has adopted specific procedures regarding the determination of the status of an order as a QMCSO. Those procedures are available free of charge upon written request to the Plan Administrator.

For a Dependent child enrolled in the Plan prior to October 1, 2018, and who is not able to support themselves because of mental or physical disability, coverage will not end upon their 26th birthday. Coverage will continue so long as they remain enrolled in the Plan. The child must have become disabled prior to attaining the specified limiting age and be dependent upon the employee for support. Proof of the child's disabling condition must be given to the Plan within 31 days of attaining the age 26. Dependent children enrolled in the Plan on and after October 1, 2018 are ineligible for this extension of coverage under the Plan once they attain age 26.

Emergency Accidental Dental Services: These are services required immediately, because of a dental accident.

Enrollment Date: This means the first day of coverage under the Plan.

Employee: The bargaining unit employees who perform work for signatory employers under a collective bargaining agreement with Heat & Frost Insulators Local 34. Employee also means active, full-time non-bargaining unit employees working a minimum of 30 hours per week for a signatory employer if such employer has signed a Participation Agreement to participate in the Plan and participation has been approved by the Board of Trustees.

Employer: An employer who is required by either a collective bargaining agreement or participation agreement to make contributions to this Plan for purposes of providing coverage to its Employees.

ERISA: The Employee Retirement Income Security Act of 1974, as amended.

Essential Health Benefits: Items and services covered within the following categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services; and chronic disease management and pediatric services, including oral and vision care for Dependents under age 19.

Facility: This is a licensed medical center, clinic, hospital, skilled nursing facility or outpatient care facility, lawfully providing a medical service in accordance with applicable governmental licensing privileges and limitations.

Habilitative Care: This is speech, physical or occupational therapy which is rendered for congenital, developmental or medical conditions which have significantly limited the successful initiation of normal speech and normal motor development. To be considered habilitative, measurable functional improvement and measurable progress must be made toward achieving functional goals, within a predictable period of time toward a Covered Person's maximum potential ability. The determination of whether such measurable progress has been made is within the sole discretion of the Plan's medical director or his or her designee, based on objective documentation.

Health Care Provider: This is any licensed non-physician (excluding naturopathic providers), lawfully performing a medical service in accordance with applicable governmental licensing privileges and limitations, who renders direct patient care to Covered Persons as covered under the Plan.

Health Care Service: This means:

- a health care procedure, treatment, or service provided by a health care facility or a physician office;
- a health care procedure, treatment, or service provided by a doctor of medicine, doctor of osteopathy, or other health professional within the scope of practice for that professional; or
- the provision of pharmaceutical products or services, medical supplies, or durable medical equipment.

Health Reimbursement Account (HRA): The Plan has established a HRA (a notional bookkeeping account) for you. Your Employer funds a specified amount per hour worked to your HRA to be used for eligible expenses (as outlined in this SPD).

Home Hospice Program: This is a coordinated program of home-based, supportive and palliative care, for terminally ill patients and their families, to assist with the advanced stages of an incurable disease or condition. The services provided are comfort care and are not intended to cure the disease or medical condition, or to prolong life, in accordance with an approved home hospice treatment plan.

Hospital: This is a licensed facility, lawfully providing medical services in accordance with governmental licensing privileges and limitations, and which is recognized as an appropriate facility under the Plan. A hospital is not a nursing home, or convalescent facility.

Illness: This is a sickness or disease, including all related conditions and recurrences, requiring medically necessary treatment.

Individual Lifetime Maximum: The dollar amount stated in the applicable Schedule of Benefits which represents the maximum benefits payable to the Employee and each of his or her eligible Dependents for all non-Essential Health Benefits for the duration of coverage.

Injury: This is an accident to the body, requiring medical treatment.

Inpatient: This is a medically necessary confinement for acute care of illness or injury, other than in a hospital's outpatient department, where a charge for room and board is made by the hospital or skilled nursing facility. The Plan covers a semi-private room, unless a physician recommends that a private room is medically necessary. In the event a Covered Person chooses to receive care in a private room under circumstances in which it is not medically necessary, payment under the Plan toward the cost of the room shall be based on the average semi-private room rate in that facility.

Investigative: As determined by HealthPartners, a drug, device, medical, behavioral health or dental treatment is investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness, or positive effect on health outcomes and will be considered investigative unless all of the following categories of reliable evidence are met:

- There is final approval from the appropriate government regulatory agency, if required. This includes whether a drug or device can be lawfully marketed for its proposed use by the United States Food and Drug Administration (FDA); and
- The drug or device or medical, behavioral health or dental treatment or procedure is not the subject of ongoing Phase I, II or III clinical trials; and
- The drug, device or medical, behavioral health or dental treatment or procedure is not under study and further studies are not needed (such as post-marketing clinical trial requirements) to determine maximum tolerated dose, toxicity, safety, effect on health outcomes or efficacy as compared to existing standard means of treatment or diagnosis; and
- There is conclusive evidence in major peer-reviewed medical journals demonstrating the safety, effectiveness and positive effect on health outcomes (the beneficial effects outweigh any harmful effects) of the service or treatment when compared to standard established service or treatment. Each article must be of well-designed investigations, using generally acceptable scientific standards that have been produced by nonaffiliated, authoritative sources with measurable results. Case reports do not satisfy this criterion. This also includes consideration of whether a drug is included in one of the standard reference compendia or "Major Peer Reviewed Medical Literature" (defined below) for use in the determination of a medically necessary accepted indication of drugs and biologicals used off-label as appropriate for its proposed use.

Major Peer Reviewed Medical Literature. This means articles from major peer reviewed medical journals that have recognized the drug or combination of drugs' safety and effectiveness for treatment of the indication for which it has been prescribed. Each article shall meet the uniform requirements for manuscripts submitted to biomedical journals established by the International Committee of Medical Journal Editors or be published in a journal specified by the United States Secretary of Health and Human Services pursuant to United States Code, title 42, section 1395x, paragraph (t), clause (2), item (B), as amended, as acceptable peer review medical literature. Each article must use generally acceptable scientific standards and must not use case reports to satisfy this criterion.

Maintenance Care: This is supportive services, including skilled or non-skilled nursing care, to assist you when your condition has not improved or has deteriorated significantly over a measurable period of time (generally a period of two months). Care may be determined to be maintenance care regardless of whether your condition requires skilled medical care or the use of medical equipment.

Medical Emergency: A sudden and unexpected onset of an illness or injury which is medically deemed to harm a patient's life or health and requires care immediately after the onset, or as soon thereafter as is reasonably possible. Heart attacks, poisoning, severe fractures, loss of consciousness or respiration, convulsions, and other similar acute conditions are medical emergencies.

Medically Necessary Care: This is health care services appropriate, in terms of type, frequency, level, setting, and duration, to the Covered Person's diagnosis or condition, and diagnostic testing and preventive services. Medically necessary care must be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue and must:

- help restore or maintain your health; or
- prevent deterioration of your condition.

The fact that an authorized Network, or Non-Network, Provider prescribes treatment does not necessarily mean the treatment is covered under this Plan.

The Plan has retained HealthPartners as the medical network provider for the Plan's Major Medical Expense Benefits. Unless otherwise stated in the Plan, in determining whether a treatment or service is Medically Necessary, the Board of Trustees will rely upon HealthPartners to make such determinations consistent with HealthPartners medical policies and such medical policies are incorporated into the Plan by reference.

Medicare: This is the federal government's health insurance program under Social Security Act Title XVIII, as amended. Medicare provides medical benefits to people who are 65 or older, or who are permanently disabled. The program has two parts: Part A and Part B. Part A generally covers the costs of hospitals and extended care facilities. Part B generally covers the costs of professional medical services. Both parts are subject to Medicare deductibles.

Mental Health Professional: This is a psychiatrist, psychologist, or mental health therapist licensed for independent practice, lawfully performing a mental health or substance use disorder service in accordance with governmental licensing privileges and limitations, who renders mental health or substance use disorder services to Covered Persons as covered under the Plan. For inpatient services, these mental health professionals must be working under the order of a physician.

Network Provider: This is any one of the participating licensed physicians, dentists, mental health, substance use disorder or other health care providers, facilities and pharmacies, who have entered into an agreement to provide health care services to Covered Persons.

Non-Network Providers: These are licensed physicians, dentists, mental health, substance use disorder or other health care providers, facilities and pharmacies not participating as Network Providers.

Out-of-Pocket Limit or Maximum: The most you must pay per person or per family per benefit year, toward allowed amounts of eligible health services. Deductibles and percentages of allowed amounts that you pay yourself count toward the out-of-pocket maximum as well as any copayments. See the definition of Out-of-Pocket Limit in the Medical Benefits section for additional information.

Outpatient: This is medically necessary diagnosis, treatment, services or supplies rendered by a hospital's outpatient department, or a licensed surgical center and other ambulatory facility (other than in a physician's office).

Network Provider/Physician: This is a licensed medical doctor, or doctor of osteopathy, lawfully performing a medical service, in accordance with governmental licensing privileges and limitations who renders medical or surgical care to Covered Persons as covered under the Plan.

Plan Administrator: The Board of Trustees is the Plan Administrator. However, the Board of Trustees has delegated certain administrative duties to Wilson-McShane Corporation, Inc. Wilson-McShane Corporation administers the Plan on a day-to-day basis. Within the SPD, Plan Administrator refers to Wilson-McShane Corporation, who administers the Plan's benefits other than the medical and HRA plan which are administered by HealthPartners, the Plan Manager and prescription benefits which are administered by ProAct.

Plan Manager: HealthPartners is the Plan Manager for the Plan's Medical Benefits and HRA Plan and administers all claims related to those benefits.

Plan Member: An Employee or Dependent who is eligible for benefits as provided by this Plan or who is eligible to continue coverage under the Plan's COBRA provisions.

Plan Year: The twelve-month period of April 1 through March 31.

Prescription Drug: This is any medical substance for the prevention, diagnosis or treatment of injury, disease or illness approved and/or regulated by the Food and Drug Administration (FDA). It must (1) bear the legend: "Caution: federal law prohibits dispensing without a prescription" or "Rx Only"; and (2) be dispensed only by authorized prescription of any physician or legally authorized health care provider under applicable state law. Drugs that are newly approved by the FDA must be reviewed by the HealthPartners Pharmacy and Therapeutics Committee. This process may take up to six months after market availability.

Provider: A health professional facility, or other program that provides eligible services within the scope of the provider's license, certification, registration, or training. Eligible providers are: ambulances; chiropractors; dentists; freestanding ambulatory surgery centers; home health agencies; hospitals; licensed consulting psychologists; licensed psychologists; medical supply companies; non-residential chemical dependency treatment centers; occupational therapists; optometrists; osteopaths; pharmacies; physical therapists; physicians; podiatrists; psychiatrists; registered nurses certified as nurse midwives, nurse anesthetists, or nurse practitioners; clinical specialists in psychiatric or mental health nursing; residential chemical dependency treatment centers; residential treatment programs for emotionally disabled children; skilled nursing facilities; and speech therapists.

Reconstructive Surgery: This is limited to reconstructive surgery, incidental to or following surgery, resulting from injury or illness of the involved part, or to correct a congenital disease or anomaly resulting in functional defect in a dependent child. A functional defect is one that interferes with a Covered Person's ability to perform activities of daily living.

Rehabilitative Care: This is a restorative service, which is provided for the purpose of obtaining significant functional improvement, within a predictable period of time, (generally within a period of two months) toward a patient's maximum potential ability to perform functional daily living activities.

Residential Behavioral Health Treatment Facility: This is a facility licensed under state law for the treatment of mental health or substance use disorders and that provides inpatient treatment of those conditions by, or under the direction of, a physician. The facility provides continuous, 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.

Skilled Nursing Facility: This is a licensed skilled nursing facility, lawfully performing medical services in accordance with governmental licensing privileges and limitations, and which is recognized as an appropriate facility by the Plan, to render inpatient post-acute hospital and rehabilitative care and services to Covered Persons, whose condition requires skilled nursing facility care. It does not include facilities which primarily provide treatment of mental health or substance use disorder.

Skilled Care: Services that are Medically Necessary and must be provided by licensed registered nurses or other eligible providers.

Totally Disabled: The inability, due wholly to injury or illness, to perform the major duties of your occupation, and because of disability, you are not engaged in any employment for wage or profit. In the case of your dependent, Totally Disabled means his or her inability to engage in substantially all of the normal activities of a person of like age in good health.

Usual and Customary Charge: The reasonable charge of the provider for a service or supply, provided that it does not exceed the provider's usual charge or the customary range for such service or supply as determined by the Plan Manager. Only usual and customary charges for eligible health services will be covered under this Plan.

ELIGIBILITY AND PARTICIPATION

Eligibility For Bargaining Unit Employees

Initial Employee Eligibility – Hourly Dollar Contributions

Contributions on behalf of an Employee are made monthly but based upon the hours worked by those employees in covered employment. The hourly contribution amount is set forth in the applicable collective bargaining agreements.

An Employee becomes initially eligible in the month following the calendar month in which total contributions received on behalf of the Employee exceed the monthly premium amount for coverage as established by the Trustees.

An Employee has a rolling six-month period in which to receive total hourly contributions in an amount sufficient to establish their initial eligibility for a month of Plan coverage.

EXAMPLE:

> The Trustees have established the monthly premium amount for Employees to be $2,000*. Mark works under a collective bargaining agreement requiring employer contributions of $11.75* per hour.
>
> Mark works 130 hours in March, with those contributions ($1,527.50) made in April. Mark then works 120 hours in April, with those contributions ($1,410) made in May.
>
> Mark will be eligible for coverage under the Plan on June 1. That is the first day of the month following the time he first has at least $2,000 of total contributions made to the Plan on his behalf.
>
> This period of initial eligibility will continue through the end of the month (June 30). In subsequent months, Mark will be able to continue coverage under the Plan by satisfying the rules set forth below for Continuation of Employee Eligibility – Dollar Bank.

*Note: The Trustees will set the monthly cost for coverage on an annual basis. The $2,000 monthly premium amount used in the examples in this section is used strictly for purposes of the examples and is not the Plan's current rate. Additionally, the $11.75 per hour rate is also a rate strictly used for example purposes and is not the current contribution rate.

Continuation of Employee Eligibility – Dollar Bank

Once an Employee is covered under the Plan for one month of coverage, he will remain covered for any succeeding month provided the total dollar amount of employer contributions made by the 15th day of the prior month is equal to or exceeds the monthly premium amount as established by the Trustees. Further, any *excess contributions* beyond what is necessary to pay for a month of coverage under the Plan will be retained in the Employee's Dollar Bank to be used for continuing their eligibility.

EXAMPLE:

> As in the example above, the Trustees have established the monthly premium amount for Plan coverage is $2,000. Mark works under a collective bargaining agreement requiring employer contributions of $11.75 per hour.

Mark earned enough total contributions due to his work in March and April to gain coverage in June. After the cost of June coverage was paid, he still had $937.50 left to pay for future coverage under the Plan. In May, Mark worked 105 hours. The corresponding contribution of $1,233.75 was made by his employer prior to the June 15th deadline.

Under this set of facts, Mark will continue to be eligible for coverage during the month of July. He is eligible because he had $2,171.25 of total contributions available to pay for that coverage once contributions for the May work month were received. Once the $2,000 cost for July Plan coverage is deducted, Mark would have $171.25 in his Dollar Bank.

Dollar Bank – Contributions and Deductions

Once established, any excess contributions over and above what is necessary to pay for a month of Plan coverage will be recorded in the Employee's Dollar Bank.

A deduction will automatically be made from an Employee's Dollar Bank to provide coverage in any month in which employer contributions are insufficient to maintain eligibility.

EXAMPLE:

Mark has built a dollar bank balance of $2,400. The required monthly premium is $2,000. Mark works 60 hours in September, and thus his employer contributes $705 on his behalf in October. This $705 contribution is insufficient for Mark to maintain eligibility in November.

The Plan will automatically deduct the necessary amount ($1,295) from Mark's Dollar Bank to provide eligibility for November. This will leave Mark with a Dollar Bank balance of $1,105.

Dollar Bank Maximum

The maximum balance of the Dollar Bank will be equivalent to nine (9) times the current monthly premium amount. For example, if the monthly premium is $2,000, the maximum Dollar Bank balance an Employee could accrue would be $18,000. Should the monthly cost of coverage increase, a corresponding increase to the maximum Dollar Bank will be made.

Note that the Dollar Bank is not a vested benefit. For small unused balances (i.e. those less than enough for a month of coverage), if you do not make a self-payment to continue coverage or regain eligiblity based on employer contributions within twelve-months of losing coverage under the Plan, any unused Dollar Bank balance will be forfeited. If you have retired, when you reach age 65, any remaining dollar bank balance will be forfeited to the Plan.

Self-Paying for Continued Coverage if Dollar Bank Balance is Insufficient

If hourly contributions and the balance, if any, in an Employee's Dollar Bank are insufficient to provide for a month's coverage, a Participant may continue their coverage under the Plan pursuant to the following rules:

- Self-paying the difference between the amount of employer contributions made on their behalf plus any Dollar Bank dollars the Participant has available and the required monthly premium contribution; or

- Electing COBRA.

EXAMPLE:

Mark has received $822.50 in employer contributions for the month of March, which is applied to pay for May coverage. He has $900 in his Dollar Bank. The monthly premium for coverage is $2,000. To continue his coverage in May, Mark may self-pay the difference of $277.50 to continue his coverage ($822.50 in employer contributions + $900 in the Dollar Bank + $277.50 self-payment = $2,000 monthly premium contribution required for coverage).

Forfeiture of Dollar Bank Upon Taking Certain Jobs

If you stop working under a collective bargaining agreement requiring contributions to the Plan, your dollar bank will be reduced to zero and you will have no right to continue to be covered under the Plan (other than any right you may have to elect COBRA Continuation Coverage), if all the following are true:

1. You work for, or as, an employer that is not obligated to contribute to the Plan;

2. The work involves the skill or skills of the trade or craft; and

3. Employer contributions would be due to the Plan on account of the work if the employer were signatory to a collective bargaining agreement requiring contributions to the Plan.

The determination regarding forfeiture of dollar bank(s) will be made in the sole discretion of the Trustees, based upon all information available to them at the time of the decision. The Trustees shall provide a 15-day advance written notice of their intent to cause a forfeiture of a participant's dollar bank. This notice shall include a summary of the factual basis upon which the forfeiture is made. A participant shall have the right to request a hearing before the Trustees regarding this decision, with such hearing to be conducted at the next regularly scheduled Trustee meeting. Claims incurred on or after the end of the 15-day notice period will be denied unless and until the Trustees reverse their forfeiture decision following the participant-requested hearing. At the hearing, the participant will be entitled to present all evidence he or she deems relevant to the matter. In addition, the Trustees may, at any time during this process, request that the participant provide such documentation and other information as may be necessary to reach a conclusion regarding the forfeiture issue. The participant's failure to respond to such request shall also serve as an appropriate basis to cause the forfeiture to occur.

The maximum period of any COBRA Continuation Coverage otherwise available after such a forfeiture will be reduced by the period of time you enjoyed Plan coverage due to the application of your dollar bank since you last worked in covered employment.

Early Retiree Eligibility for Bargaining Unit Employees

RETIREE COVERAGE IS NOT A VESTED BENEFIT. THE TRUSTEES MAY CHANGE THESE RETIREE ELIGIBILITY RULES, THE LEVEL OF BENEFITS PROVIDED, OR THE COST OF SUCH COVERAGE AS THEY DEEM NECESSARY OR ADVISABLE.

Bargaining unit employees who are: 1.) Participants in the Plan on the date of retirement, 2.) At least age 52, and 3.) Have a minimum of 5 consecutive years of credited service under the Plan ending in either the year of Retirement or the year prior to Retirement, will have the option of electing Retiree Coverage as described in this section. Retiree coverage may be elected in lieu of COBRA continuation coverage. If you elect COBRA coverage, you still will need to provide the Plan Office with a Declaration of Retirement during this COBRA period of coverage in order to preserve your right to retiree coverage. See the explanation below.

Retirement means you have permanently discontinued employment in a position for which contributions must be made to the Plan on your behalf. **You must complete a Declaration of Retirement on a form approved by the Trustees in order to be eligible for this retiree benefit. You must submit this form no later than December 31st of the year of your Retirement in order to preserve your eligibility for these benefits.** Following submission of the Declaration of Retirement, the Plan will not reduce your self-pay, COBRA, or retiree premiums to reflect any further employer contributions made on your behalf, except in cases where such contributions are sufficient to regain eligibility as an active employee and you elect to be covered as such.

Those who chose this retiree coverage and who then return to active employment may elect to maintain the retiree coverage through self-payments, or may choose to be covered as an active employee, subject to the rules for initial eligibility described above. **A retiree who terminates enrollment in the retiree program due to coverage as an active employee will be eligible for such retiree coverage only if he or she meets each of the requirements stated above at the time of his or her re-retirement.**

Credited Service

Credited service hours are hours for which a participating employer makes contributions to the Trust while you are working either as a permit employee or as a member of Local 34.

Credited hours include reciprocal hours earned on and after January 1, 2017 from another plan when traveling as a member of Local 34. Hours worked as a traveling member of another local union do not count as credited hours.

Credited hours also include hours credited during a period of disability according to the terms of the section entitled Continuation Coverage.

For purposes of this Retiree Coverage, the following rules apply with regard to your accumulation of credited service.

Participants age 55 and older as of April 1, 2021

For participants who are age 55 and older as of April 1, 2021, one (1) year of credited service equals 1,200 hours under the Plan in a calendar year.

If you are credited with less than 1,200 hours in a calendar year, no credited service will be granted; there will be no partial years of credited service. Your credited service will be calculated as soon as administratively feasible following the end of the year and will remain fixed throughout the calendar year. That is, even if you are credited with 1,200 hours in a specific year, you will not be granted a year of credited service until the following January.

Participants younger than age 55 as of April 1, 2021

For participants who are younger than age 55 as of April 1, 2021, credited service is defined as follows:

- 1,400 – 1,499 hours under the Plan in a calendar year will equal 0.5 of a year of credited service;
- 1,500 – 1,599 hours under the Plan in a calendar year will equal 0.75 of year of credited service;
- 1,600 hours or more under the Plan in a calendar year will equal one (1) year of credited service.

If you are younger than age 55 on April 1, 2021 and are credited with less than 1,400 hours in a calendar year, no credited service will be granted. Your credited service will be calculated as soon as

administratively feasible following the end of the year and will remain fixed throughout the calendar year. That is, even if you are credited with 1,400 hours or more in a specific year per the above schedule, you will not be granted your credited service until the following January.

Cost of Retiree Coverage

The full cost of retiree coverage will be the actuarially determined anticipated cost of the medical, dental and life insurance benefits for participants in the age range of 52 to 65. This amount will be calculated on a composite basis and will be adjusted annually to reflect changes in the anticipated cost of those benefits. Your cost for Retiree Coverage will be determined by multiplying the full cost of retiree coverage times a percentage based on your age and total years of credited service under the Plan. The table below shows the applicable percentage based on your age and years of credited service.

Years of Credited Service	Age 52 - 61	Age 62 - 65
30	50.0%	0.0%
29	52.0%	4.0%
28	54.0%	8.0%
27	56.0%	12.0%
26	58.0%	16.0%
25	60.0%	20.0%
24	62.0%	24.0%
23	64.0%	28.0%
22	66.0%	32.0%
21	68.0%	36.0%
20	70.0%	40.0%
19	72.0%	44.0%
18	74.0%	48.0%
17	76.0%	52.0%
16	78.0%	56.0%
15	80.0%	60.0%
14	82.0%	64.0%
13	84.0%	68.0%
12	86.0%	72.0%
11	88.0%	76.0%
10	90.0%	80.0%
9	92.0%	84.0%
8	94.0%	88.0%
7	96.0%	92.0%
6	98.0%	96.0%
5	100.0%	100.0%

Example: Joe Smith retirees at age 60, and meets each of the requirements for retiree eligibility described above. Assume Joe has 25 years of credited service at the time of his retirement. Assume also that the Plan has determined that the full monthly cost of retiree coverage would be $1,600 per month. Until Joe turns 62, his monthly premium for retiree coverage will be 60% of the cost of retiree coverage. For the first year that will be $960 ($1,600 X 60%). When Joe turns 62, his monthly premium for retiree coverage will drop to 20% of the cost of retiree coverage, or $320.00.

Termination of Retiree Coverage

Retiree coverage will terminate on the earliest of the following events:

1. Your death;

2. Your attaining age 65 (including a covered spouse when they turn age 65);

3. Your becoming eligible under the Plan as an active employee;

4. Your failure to timely pay the required premium for retiree coverage;

5. Termination of the Plan; or

6. Termination or alteration of the retiree eligibility provisions by the Trustees, causing you to lose retiree coverage.

7. Effective on and after June 1, 2006, your retiree coverage (whether early retiree coverage or Medicare Supplement coverage) will terminate and you will have no right to continue to be covered under the Plan <u>if all of the following are true</u>:

   a. You work for, or as, an employer that is not obligated to contribute to the Plan;
   b. The work involves the skill or skills of the trade or craft; and
   c. Employer contributions would be due to the Plan on account of the work if the employer were signatory to a collective bargaining agreement requiring contributions to the Plan.

   The determination regarding termination of retiree coverage shall be made in the sole discretion of the Trustees, based upon all information available to them at the time of the decision. The Trustees shall provide a 15-day advance written notice of their intent to cause this termination. This notice shall include a summary of the factual basis upon which the termination is made. A participant shall have the right to request a hearing before the Trustees regarding this decision, with such hearing to be conducted at the next regularly scheduled Trustee meeting. Claims incurred on or after the end of the 15-day notice period will be denied unless and until the Trustees reverse their decision following the participant-requested hearing. At the hearing, the participant will be entitled to present all evidence he or she deems relevant to the matter. In addition, the Trustees may, at any time during this process, request that the participant provide such documentation and other information as may be necessary to reach a conclusion regarding the forfeiture issue. The participant's failure to respond to such request will be an appropriate basis to cause the termination to occur.

   The maximum period of any COBRA Continuation Coverage otherwise available after such a forfeiture will be reduced by the period of time you enjoyed retiree coverage under the Plan.

Medicare Supplemental Reimbursement Benefit

<u>Benefit Eligibility</u>: Effective on and after April 1, 2021, former bargaining unit employees will be eligible to receive this reimbursement benefit if they:

1. Have eighteen (18) total years of coverage under the Plan: and

2. Have five (5) consecutive years of coverage under the Plan immediately prior to retirement.

If you do not meet both the above service requirements, you are ineligible for this reimbursement benefit.

To receive the reimbursement benefit, you must be enrolled in Medicare and in a Medicare Supplemental Plan as further described below.

Benefit expiration: As of April 1, 2021, recipients will have their reimbursement benefit expire under the following terms or their death, whichever is earliest:

1. For recipients who, as of April 1, 2021, are age 74 or older, the reimbursement benefits will terminate on March 31, 2022;

2. For recipients who, as of April 1, 2021, are age 71 but less than age 74, the reimbursement benefit will terminate as of December 31, 2022;

3. For current and future recipients as of April 1, 2021, who are not yet age 71, the reimbursement benefit will terminate as of the end of the month as of the earlier of (1) your attainment of age 72, or seven (7) years of coverage under the Medicare Supplemental Reimbursement Benefit. However, if you were both (a) under the age of 65, and (b) disabled as of June 1, 2018, your benefits will terminate as of May 31, 2025.

Reimbursement Benefit Amount: A former bargaining unit employee will receive reimbursement for premiums actually paid for medical coverage supplemental to Medicare for the participant and his or her spouse, up to a maximum benefit of $300 per month. Even if the cost exceeds this amount, the amount reimbursed by the Plan will not exceed the maximum. To receive reimbursement, you must submit a copy of the premium billing and a claim form indicating the premium has been paid to the Plan Administrator.

Plans Subject to the Reimbursement Benefit: Plans eligible for reimbursement under this benefit are plans offered through a private insurer that pays for some of the hospital and medical costs that Medicare (Part A and B) does not cover such as copayments, coinsurance and yearly deductibles. Such plans also include Medicare Supplement Plans (Medigap Plans), Medicare Advantage Plans (Part C) and Medicare Rx Plans (Part D).

Spousal Eligibility: In the case of a **retiree** eligible for coverage under this reimbursement benefit, but whose spouse has not yet reached the age of 65, such spouse will continue to be eligible for Plan coverage per the following premium schedule:

1. Non-Medicare eligible spouses covered *as of* April 1, 2021: For a non-Medicare spouse covered by the Plan as of April 1, 2021, the cost of coverage will be 75% of the applicable monthly retiree premium that would apply to a participant who was under age 62 (regardless of the participant's or spouse's actual age), enrolled in Retiree Coverage under this Plan, and had the same number of years of Credited Service.

2. Non-Medicare eligible spouses of participants who become eligible for Medicare *on and after* April 1, 2021: For non-Medicare spouses of participants who become eligible for Medicare on and after April 1, 2021, the monthly cost of coverage for such non-Medicare covered spouse will be 100% of the applicable retiree premium that would apply to a participant who was under age 62 (regardless of the participant's or spouse's actual age), enrolled in Retiree Coverage under this Plan, and had the same number of years of Credited Service.

This spousal coverage under the Plan terminates on the first day of the month in which the spouse reaches age 65.

Eligibility for Non-Bargaining Unit Employees

Employers who employ bargaining unit employees may elect, with the agreement of the Board of Trustees, to cover their non-bargaining unit employees under the Plan. Such employers have 60 days from the date they first became signatory to the bargaining agreement to exercise this option by signing a Participation Agreement allowing for non-bargaining employee participation. If so elected, all non-bargaining unit employees must be covered by the Plan unless the non-bargaining unit employee opts out of coverage due to coverage for their spouse's employer.

Non-bargaining unit employees of an employer who exercises this option become eligible on the date the Participation Agreement is signed, or the date they become an eligible employee, whichever is later. Employers must enroll employees in the Plan within 60 days of the date they become eligible.

Non-bargaining unit employees are not eligible for the Medicare Supplement Benefit, retiree coverage, or the weekly disability benefit. A non-bargaining unit employee covered by the Plan, who begins working as a bargaining unit employee, shall become covered as a bargaining unit employee after he or she meets the initial eligibility requirements described for bargaining unit employees.

Coverage During Periods of Military Service

You must inform the Plan Administrator in writing as soon as you know that you are entering military service.

1. For Dependents Entering into Military Service

   Coverage for a Dependent shall cease on the date that Dependent enters military service.

2. For Employees Entering into Military Service

   Employees entering into military service (and their Dependents) may elect to have their coverage frozen during military service (see Freezing Coverage, below) or may elect to continue coverage during that period (see Military Continuation Coverage, below).

3. Freezing Coverage

   Unless you and your Dependents choose Military Continuation Coverage, coverage for you and your Dependents will discontinue on the date you enter military service. Your eligibility status will be frozen when you enter military service and will be fully restored when you are honorably discharged and timely return to work with a contributing employer. The time limits for returning to work are described in the section entitled Coverage Following Military Service, below.

4. Military Continuation Coverage

   Once the Plan Administrator has been notified that you are entering military service, you and your Dependents will be allowed to purchase Military Continuation Coverage. Military Continuation Coverage is provided as follows:

   a. The election procedures and coverage options will be the same as those that are available under COBRA continuation coverage.

b. You may elect to freeze your reserve dollar bank. If you choose this option, your eligibility will be automatically reinstated when you are honorably discharged from military service and return to employment within the time limits listed below.

c. Alternatively, if you choose not to freeze coverage, you may either:

i. First exhaust your bank to continue coverage, followed by self-paying for up to 24 months of coverage. *If you choose this option, your eligibility status will not be frozen.* Following discharge, you may need to satisfy the initial eligibility requirements of the Plan before you and your dependents will be covered again although you may elect to make self-payments to reinstate coverage until such time as there is sufficient employer contributions for your coverage; or,

ii. You may choose not to access your reserve dollar bank, and immediately begin making self-payments for coverage for up to 24 months of coverage. If you choose this option, following discharge from military service, your coverage will be automatically reinstated when you are honorably discharged from military service and return to employment within the time limits listed in No. 6 below.

d. You must submit payment of the self-pay contributions to the Plan Administrator by the first day of each month. If a payment is not received within 30 days of that due date, coverage will be retroactively terminated to the due date.

5. Termination of Military Continuation Coverage

Military Continuation Coverage will terminate on the earliest of:

a. The first day of the month for which a required and on-time self-payment is not received;

b. The end of 18 months of self-paid Military Continuation Coverage (not including coverage obtained through the hours contained in your dollar bank), or

c. The day after the last date on which you are required to apply for or return to a position of employment with a contributing Employer (shown in the chart Time Limits to Return to Work, below).

6. Coverage Following Military Service

If you elect no Military Continuation Coverage (that is, if you freeze your coverage in the Plan), or if you do not use your dollar bank to pay for that coverage, your eligibility status is frozen when you enter military service provided that you have notified the Plan Administrator of your entry into military service. If you and your dependents were eligible for coverage when you entered active duty, you will be covered again when you are honorably discharged and return to work for a contributing Employer within the time limits provided below. These time limits may be extended if you have suffered a service-connected injury or illness. You should contact the Plan Administrator if this has occurred.

You must be honorably discharged and return to work for a contributing employer within the following time limits, (or be available to work if no work is available), to be eligible to have your frozen eligibility status restored.

Time Limits to Return to Work

If you were in military service	You must
1 to 30 days	Report to your employer (or another contributing employer) by the beginning of the first regularly scheduled work day commencing more than eight hours after you return home.
31 to 180 days	Submit an application for re-employment to your employer (or another contributing Employer) within 14 days after the completion of your service.
More than 180 days	Submit an application for re-employment to your employer (or another contributing Employer) within 90 days after completion of your service.

If you do not return to work with the same contributing Employer, you should notify your Local Union that you are available for work with a contributing employer. Also, you must submit your discharge papers to the Plan Administrator within 14 days of the date you return to work for a contributing Employer.

Enrollment

(Applicable to All Covered Employees)

Bargaining unit employees who satisfy the eligibility requirements will automatically receive an enrollment card to be completed and returned to the Plan Administrator. Non-bargaining unit employees and their eligible dependents can be enrolled in this Plan without proof of insurability within 60 days of the employee's hire date or change to eligible status (e.g., changes from part-time to full-time). Enrollment for non-bargaining unit employees is accomplished by the employer adding the employee to the monthly list bill and returning their enrollment card along with the required premium.

Employees may also apply within 30 days of marriage to add coverage for an eligible spouse. A newborn, adopted, foster, or step child can be added within 30 days of the birth, adoption, or official residence in the employee's home, as appropriate.

Family and Medical Leave

(Applicable to All Covered Employees)

The Family and Medical Leave Act generally requires employers of 50 or more employees within a 75-mile area to provide up to 12 weeks of unpaid leave to certain eligible employees for specified family and medical reasons. The Plan will provide continued coverage for participants who take a qualifying FMLA leave, if the leave commences while the participant is eligible for benefits under the Plan. In addition, the participant will not subsequently be required to re-qualify under the Plan's eligibility rules solely because of hours not worked during the period of the leave.

Employers *will not* be required to continue contributions to the plan during the time the employee is on unpaid leave. For purposes of determining eligibility, participants will be credited with coverage during the period of unpaid leave. During the leave, employees may not engage in any work within the industry.

In order to administer this policy, employers must provide written documentation to the Plan Administrator when an eligible employee takes a qualifying FMLA leave. Documentation must include the reason for the leave, certification that the leave is in fact a qualifying leave, and the beginning/ending dates of the leave.

Effective Date of Coverage

(Applicable to All Covered Employees)

Benefits become effective on:

1. The date you become eligible if you are a bargaining unit employee, or

2. The first day of the month following the date you are enrolled if you are a non-bargaining unit employee, or,

3. The date of dependent acquisition such as marriage, birth, or adoption for eligible dependents, if application for coverage is made within 30 days of the date of acquisition.

Except in situations where participants provide a Certificate of Creditable Coverage:

1. If the employee is absent from work due to illness or injury on the effective date of coverage, coverage will start when the employee returns to active full-time work, or becomes available for such work. If the effective date is a work holiday, coverage will start on that day provided the employee worked full-time on the last work day immediately preceding the work holiday.

2. If a dependent, other than a newborn child born while coverage is in force, is hospital confined on the effective date of coverage, his or her coverage will start on the day following the day he or she is finally discharged from the hospital.

If both parents are covered as Employees under this Plan, only one may elect Dependent coverage.

Termination of Coverage

(Applicable to All Covered Employees)

In addition to specific termination provisions set forth above, coverage under this Plan will end on the earliest of the following dates:

1. The first day of the month for which you do not have a sufficient balance in your Dollar Bank to maintain eligibility, if a bargaining unit employee, or, if a non-bargaining unit employee, on the last day of the month for which premiums for coverage have been paid.

2. The date on which the employee or dependent ceases to be eligible as defined in this Plan.

3. The date the dependent becomes covered as an employee under this Plan.

4. The last day of the month in which the employee dies.

5. With respect to a specific coverage item, the date the coverage ends or the date the individual lifetime maximum has been paid.

6. The date this Plan ends.

Under the Health Insurance and Portability and Accountability Act of 1996, you have the right, upon termination of coverage, to receive a Certificate of Creditable Coverage from the Plan. That Certificate states the length of time that you were covered under the Plan. Effect of Multiple Bases for Eligibility

On occasion, an individual may be eligible for coverage under the Plan for more than one reason. For example, an individual may be covered both as an active participant and as the spouse of an active participant. Or, a child whose parents are both active participants could be deemed a dependent of each of those individuals.

Even when an individual is eligible for coverage on more than one basis, all of the limitations on coverage and benefits maximums expressed in this booklet will apply only as stated: they will not be doubled or tripled. For example, a dependent child of two active participants will still be subject to the Plan's $1,500 lifetime Orthodontia maximum – it will not be $3,000 just because the child is eligible for coverage on two different bases.

CONTINUATION COVERAGE

(Applicable to All Covered Employees)

You and your eligible dependents have the opportunity for a temporary extension of medical and dental coverage at group rates in certain instances where coverage under the Plan would otherwise end. This is known as continuation coverage or COBRA coverage, after the law that provides for such coverage.

Qualified Beneficiary

A "Qualified Beneficiary" is any person who, as of the day before a Qualifying Event, is:

1. An employee of an Employer covered under the Plan as of such day (such persons are called "Covered Employees"),

2. The spouse of an Employee covered under the Plan as of such day (such persons are called "Covered Employees"),

3. A dependent of the Covered Employee (including any child born or placed for adoption with the Covered Employee during the COBRA coverage period).

A retiree or other former Employee actively participating in the Plan by reason of a previous period of employment shall be treated as a Qualified Beneficiary.

Qualifying Events

If you are a Covered Employee, you have a right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than your gross misconduct).

If you are the spouse of a Covered Employee, you have the right to choose continuation coverage for yourself if you lose coverage under the Plan for any of the following four reasons:

1. The death of your spouse;

2. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;

3. Divorce or legal separation from your spouse; or

4. Your spouse becomes covered by Medicare.

If you are a dependent child of a Covered Employee, you have the right to elect continuation coverage if you lose coverage under the Plan for any of the following five reasons:

1. The death of the parent who is the Covered Employee;

2. The termination of the Covered Employee's employment (for reasons other than gross misconduct) or reduction in the covered parent's hours of employment;

3. Parents' divorce or legal separation;

4. The parent who is the Covered Employee becomes covered by Medicare; or

5. You cease to be a "dependent child" under the Plan.

Election of Continuation Coverage

If there is a choice among types of coverage under the Plan, each of you who is eligible for continuation of coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child is entitled to elect continuation of coverage even if the covered employee does not make that election. Similarly, a spouse or dependent child may elect a different coverage from the coverage that the employee elects.

NOTE: ***You or the affected family member has the responsibility to inform the administration office within 60 days of a divorce, legal separation, a child losing dependent status under the Plan or receipt of a determination of total disability from the Social Security Administration (SSA). In providing notice, you must provide documentation to support the COBRA qualifying event. In cases of divorce, a copy of the divorce decree or similar documentation must be provided. In case of a dependent child losing dependent status, documentation indicating the date the loss of dependent status occurred must be provided. In the case of extending coverage due to a determination of total disability, a copy of the SSA determination letter.*** **Failure to notify the Plan Administrator and provide the necessary documentation may result in the loss of your right to continuation coverage.**

When the Plan Administrator is notified that one of these events has happened, it will in turn notify you that you have the right to choose continuation coverage. You have at least 60 days from the date you would lose coverage because of one of the events described above to inform the administration office that you want continuation coverage.

If you do not choose continuation coverage, your coverage under the Plan will end.

A Qualified Beneficiary electing continuation coverage has 45 days after electing continuation coverage in which to make his or her initial payment. The initial payment must be sufficient to pay for all current and retroactive premiums, back to the date coverage would otherwise have been lost due to the Qualifying Event.

Continuation coverage premium payments must be made monthly. After the initial premium payment, each subsequent monthly premium payment is due by the first day of the benefit month for which the premium payment is being made (the "due date"). If the premium payment is not made within the time allowed, continuation coverage for all Qualified Beneficiaries will terminate. The premium payment may not be made up nor may coverage be reinstated by making past due or future premium payments.

The amount of the premiums is determined by the Trustees based on federal regulations. The amounts are subject to change, but not more often than once per year unless substantial changes are made in the benefits.

Duration of Continuation Coverage

Unless terminated earlier for the reasons stated below, the maximum period of time for continuation coverage resulting from an employee's termination or reduction in hours is 18 months for the employee, the spouse, and dependent children. This maximum period may be extended for up to an additional 11 months (29 months total) if (1) the Social Security Administration (SSA) determines within the 18 month period that a Qualified Beneficiary was disabled at any time during the first 60 days of COBRA eligibility and the Qualified Beneficiary remains disabled; and (2) the Qualified Beneficiary notifies the Plan of the

SSA disability determination within 60 days of receiving the determination and provides a copy of the SSA disability determination.

The spouse and dependent children of the employee are entitled to a maximum period of continuation coverage of thirty-six (36) months if a Qualifying Event occurs other than a termination or reduction in hours of employment. Thirty-six (36) months is also the maximum period of time that the spouse and dependent children can have continuation coverage even if one or more new Qualifying Events occur while they are covered under continuation coverage.

For example, suppose that your death occurs while you are making premium payments for COBRA coverage because of reduced hours. You and your family had been covered under COBRA coverage for six (6) months before your death. Since your death is a qualifying event for your dependents, your spouse elects to continue coverage by making premium payments for himself/herself and your dependent children. Your spouse is entitled to continue coverage for himself/herself and the Dependent children for an additional thirty (30) months (the maximum coverage period of thirty-six (36) months minus the number of months of premium payments you had already made (36 - 6 = 30)).

Then, after your spouse has continued coverage for fifteen (15) of the remaining thirty (30) months for himself/herself and the dependent children, one of the dependent children who was a student graduates and loses dependent status. This is a Qualifying Event for the dependent child entitling him to make premium payments for COBRA coverage for himself. However, the thirty-six (36) month maximum coverage period is reduced by the twenty-one (21) months of COBRA coverage already received (six (6) months from your Self-Contributions before your death plus fifteen (15) months from your spouse's Self-Contributions). The graduate is, therefore, entitled to make premium payments for COBRA coverage for up to an additional fifteen (15) months (36 - 21 = 15).

Another circumstance of extended COBRA coverage would involve a situation when the qualifying event is the end of your employment, and you become entitled to Medicare benefits less than 18 months before your qualifying event. COBRA Continuation Coverage for Qualified Beneficiaries other than you lasts until 36 months after the date of Medicare entitlement. For example, if you became entitled to Medicare 8 months before the date on which your employment ended, COBRA coverage for your spouse and children can last up to 36 months after the date of the qualifying event (36 months minus 8 months). If you, your spouse or a dependent are disabled when you elect this coverage or become disabled within the first 60 days after you elect to continue coverage under COBRA, it may be extended for a period of up to 29 months.

To take advantage of the rules allowing for extended COBRA coverage, evidence supporting the occurrence of the second qualifying event must be provided to receive the extended COBRA coverage. As mentioned previously, in case of a divorce, a copy of the divorce decree or similar documentation must be provided, in the case of a dependent child ceasing to be a dependent, documentation evidencing the loss of dependent status, or in the case of a disability determination, a copy of the SSA disability determination.

Termination of Continuation Coverage

The law also provides that a Qualified Beneficiary's continuation coverage may be cut short for any of the following four reasons:

1. The Heat and Frost Insulators Local 34 Health & Welfare Plan no longer provides group health coverage to any employees of a participating employer;

2. The premium for your continuation coverage is not paid within 30 days of the date due;

3. A Qualified Beneficiary first becomes covered under another group health plan after the date of the COBRA election; however, if the new coverage contains any exclusion or limitation with respect to any pre-existing condition of the beneficiary, then this coverage does not end the continuation coverage period;

4. A Qualified Beneficiary becomes covered by Medicare after the date of the COBRA election.

Cost of Continuation Coverage

You do not have to show that you are insurable to choose continuation coverage. However, except as described below, you must pay the full rate for your continuation coverage. The following exceptions apply only to bargaining unit employees.

1. Shortage of Dollar Bank: If a bargaining unit employee's coverage terminates due to a shortage of dollars in their dollar bank, the cost of continuation coverage will be reduced by the amount of any dollars that remain in their dollar bank.

2. Total Disability: If a bargaining unit employee is determined to be Totally Disabled, the employee will be able to continue their coverage at no cost for up to six (6) months from the end of the month in which they last worked, regardless of the date they were determined to be Totally Disabled. There is no grandfathering of bargaining unit employees determined to be Totally Disabled prior to November 1, 2020. If a bargaining unit employee was determined to be Totally Disabled prior to November 1, 2020 and has already continued coverage for six (6) months from the end of the month they last worked, their coverage will terminate on November 1, 2020.

   Thereafter, bargaining unit employees may continue their coverage via COBRA for up to an additional eighteen (18) months after their initial six (6) months of no cost for coverage due to Total Disability. Exception for Terminal Illness: In circumstances where a bargaining unit employee provides a letter to the Plan from their doctor stating (1) the bargaining unit employee's specific condition, and (2) that the bargaining unit employee is terminally ill and has a limited remaining life expectancy, the Plan will reduce the terminally ill bargaining unit employees COBRA premium by 75% for their first 18 months of COBRA coverage.

   Dollar Bank Credit: While an employee is Totally Disabled, the employee will receive dollar bank credit commensurate with a pro-rata weekly cost for coverage for each week of total disability, and the cost of continuation coverage will be determined as described in paragraph 1, above.

   Total Disability Runs Concurrently with COBRA: This Total Disability Coverage period will run concurrently with the 18-month COBRA coverage period. If an employee is no longer disabled prior to the expiration of the 18-month COBRA coverage period, the employee may continue their coverage through the end of the 18-month COBRA coverage period by making the applicable COBRA coverage premium payment(s).

   Dollar Bank – Return Before End of 18-month COBRA Coverage Period: If an employee returns from Total Disability to active work before the end of the 18-month COBRA coverage period, any available Dollar Bank dollars will be available for use to reduce COBRA premiums as described below, but such Dollar Bank dollars will not be used to re-establish coverage for Active eligibility status.

   If the employee is unable to establish Active eligibility status based on a combination of hours worked and disability credit hours before the end of the 18-month COBRA coverage period, the

employee may pay the applicable COBRA coverage premium to retain coverage. If an employee elects COBRA for that coverage month, the premium amount will be reduced by the sum of the Dollar Bank (if any) and disability credit hours. Thereafter, the employee will have to establish active eligibility status via employer contributions or, if unable to have enough dollars contributed to establish active eligibility, continue their coverage by making the required full COBRA premium payment.

Total disability coverage will be extended up to an additional 11 months (thus, up to a total of twenty-nine (29) months) for employees who have received a determination of totally disabled status from the Social Security Administration as described under Duration of Continuation Coverage.

3. Death of Bargaining Unit Employee: If a bargaining unit employee dies (including bargaining unit employees covered on a self-pay basis), continuation coverage for a qualified beneficiary(s) will be continued at no cost for a period of one year from the end of the month in which death occurred.

Fraudulent Information and Reporting

If benefit claim payments, employer contributions or Self-Contributions are made on behalf of any Participant which rely on misleading or fraudulent information provided by the Participant or Employer, coverage for the Participant and his/her Dependents involved in the fraudulent activity will be immediately terminated and dollar bank, if any, will be forfeited. Further, the Participant will have no entitlement to and will forfeit contributions made to the Plan going forward. The Participant and his/her Dependents will only be able to re-enroll and become eligible for coverage under the Plan upon specific application to and the approval of the Board of Trustees. The termination of coverage will be from the time of the discovery of the fraud going forward.

Rescission of Coverage

The Plan may rescind your coverage for fraud, intentional misrepresentation of a material fact, a material omission, or any other circumstance in which you receive benefits to which you are not entitled under the terms of the Plan after the Plan provides you with 30 days advance written notice of that rescission of coverage.

The Trustees have the right to determine, in their sole discretion, whether there has been fraud, an intentional misrepresentation of a material fact, a material omission or any other circumstance in which you receive benefits to which you are not entitled under the terms of the Plan.

A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that it will be effective back to the time that you should not have been covered by the Plan. However, the following situations will not be considered rescissions of coverage and do not require the Plan to give you 30 days advance written notice:

- The Plan terminates your coverage back to the date of your loss of employment when there is a delay in administrative recordkeeping between your loss of employment and notification to the Plan of your termination of employment.
- The Plan retroactively terminates your coverage because of your failure to timely pay required premiums or contributions for your coverage.
- The Plan retroactively terminates your former spouse's coverage back to the date of your divorce. The spouse will have the option of COBRA coverage effective from the first day of the month of the divorce, if you timely notify the Fund Office of the divorce.

For any other unintentional mistakes or errors under which you and your Dependents were covered by the

Plan when you should not have been covered, the Plan will cancel your coverage prospectively – going forward – once the mistake is identified. Such cancellation will not be considered a rescission of coverage and does not require the Fund to give you 30 days advance written notice.

MEDICAL BENEFITS

Effective January 1, 2022, the Plan has contracted with HealthPartners to provide for a preferred provider network for your medical benefits. As of that date, HealthPartners administers all Medical and HRA Plan claims for the Plan and is designated as the Plan Manager for those benefits.

How to use this Network

This SPD describes your Covered Services and how to obtain them. **The Plan provides Network Benefits and Non-Network Benefits from which you may choose to receive Covered Services.** Coverage may vary according to your network or provider selection. The provisions below contain information you need to know in order to obtain Covered Services.

Network Provider. This is any one of the participating licensed physicians, dentists, mental health, substance use disorder or other health care providers, facilities and pharmacies, who have entered into an agreement to provide health care services to Covered Persons.

Network providers are available to view free of charge by logging on to your "*my*HealthPartners" account at healthpartners.com. If you need assistance locating a physician or other health care provider in your network, please contact Member Services.

Non-Network Providers. These are licensed physicians, dentists, mental health, substance use disorder or other health care providers, facilities and pharmacies not participating as Network Providers.

About the HealthPartners Provider Network

To obtain Network Benefits for Covered Services, you must select and receive services from Network Providers.

Network. These are the health care providers and facilities contracted to provide services for this Plan.

Designated Physician, Provider, Facility or Vendor. This is a current list of network physicians, providers, facilities or vendors who are authorized to provide certain Covered Services as described in this SPD. Call Member Services or log on to your "*my*HealthPartners" account at healthpartners.com for a current list.

Network Clinics. These are participating clinics providing ambulatory medical services.

Continuity of care. In the event you must change your current primary care physician, specialty care physician or general hospital provider because that provider leaves the network or because your Plan changed health plan offerings, you may have the right to continue receiving services from your current provider for a period of time. Some services provided by Non-Network Providers may be considered a covered Network Benefit for up to 120 days under this Plan if you qualify for continuity of care benefits under state or federal laws.

The following conditions qualify for this benefit:

- An acute condition;
- A life-threatening mental or physical illness;
- Pregnancy for which you have begun care;
- A physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death; or
- A disabling or chronic condition that is in an acute phase.

You may also request continuity of care benefits for culturally appropriate services or when we do not have a provider who can communicate with you directly or through an interpreter. Occasionally, HealthPartners may, in its sole discretion, apply a previous carrier's approach to coverage for a limited period of time to accommodate a Covered Person's specific needs for continuity of care when an Employer is moving from another carrier to HealthPartners coverage.

Terminally ill patients are also eligible for continuity of care benefits. Continuity of care may continue for the rest of the Covered Person's life if a physician, advanced practice registered nurse, or physician assistant certifies that the Covered Person has an expected lifetime of 180 days or less.

Continuity of care benefits will not be available or may be discontinued if the provider is terminated from the network for misconduct.

Call Member Services for further information regarding continuity of care benefits.

Prior authorization for services

Your physician may be required to obtain prior authorization for certain services. Your physician will coordinate the prior authorization process for any services which must first be prior authorized. You may call the Member Services Department or log on to your "*my*HealthPartners" account at healthpartners.com for a list of which services require your physician to obtain prior authorization.

HealthPartners medical or dental directors, or their designees, will determine medical necessity and appropriateness of certain treatments based on established medical policies, which are subject to periodic review and modification.

Second opinions for network services. If you question a decision or recommendation about medical care, the Plan covers a second opinion from an appropriate Network Provider.

MEDICAL SCHEDULE OF BENEFITS

The amount that the Plan pays for Covered Services is listed below. The Covered Person is responsible for the specified dollar amount and/or percentage of charges that the Plan does not pay.

To be covered under this Plan, the medical or dental services or items described below must be medically necessary or dentally necessary.

Coverage is subject to the exclusions, limitations, and other conditions of this SPD.

Covered Services and supplies are based on established medical policies, which are subject to periodic review and modification by the medical or dental directors. Covered prescription drugs which are administered in a clinic or hospital setting are based on requirements established by the HealthPartners Pharmacy and Therapeutics Committee, and are subject to periodic review and modification. The Medical Coverage Criteria and formulary requirements are available by logging on to your "*my*HealthPartners" account at healthpartners.com or by calling Member Services.

Coverage may vary according to your network or provider selection.

Non-Network Providers: Except for air ambulance, emergency care, certain post-stabilization care, and certain non-emergency services from Non-Network Providers at certain Network facilities as required under the federal No Surprises Act and its implementing regulations, when you use Non-Network Providers, benefits are substantially reduced and you will likely incur significantly higher out-of-pocket expenses. A Non-Network Provider may not have an agreement with HealthPartners to provide services at the discounted fee. In the absence of a contracted rate, Non-Network Benefits are restricted to the usual and customary amount as described under the definition of "Charge". If the Non-Network Provider's billed charges are over the usual and customary amount, you pay the difference, in addition to any required deductible, copayment and/or coinsurance, and these charges do not apply to the out-of-pocket limit.

Charge: For Covered Services delivered by participating Network Providers or Non-Network Providers that have a contract with the Plan Manager, this is the provider's contracted rate for a given medical/surgical service, procedure or item.

For Covered Services delivered by Non-Network Providers that do not have a contract with the Plan Manager, this is the usual and customary charge. The usual and customary charge is determined using the following options in the following order, depending on availability: (1) 140% of the Medicare fee schedule; (2) a comparable schedule if the service is not available on the Medicare fee schedule; or (3) a commercially reasonable rate for such service.

A charge is incurred for covered ambulatory medical, inpatient professional fees, and surgical services on the date the service or item is provided. A charge is incurred for covered inpatient facility fees on the date of admission to a hospital. To be covered, a charge must be incurred on or after the Covered Person's effective date and on or before the termination date.

Copayment/Coinsurance: The specified dollar amount, or percentage, of charges incurred for Covered Services, which the Plan does not pay, but which a Covered Person must pay, each time a Covered Person receives certain medical services, procedures or items. The Plan's payment for those Covered Services or items begins after the copayment or coinsurance is satisfied. Covered Services or items requiring a copayment or coinsurance are specified in this SPD.

For services provided by a Network Provider:

The amount which is listed as a percentage of charges or coinsurance is based on the Network Providers' discounted charges, calculated at the time the claim is processed, which may include an agreed upon fee schedule rate for case rate or withhold arrangements. However, if a Network Providers' discounted charge for a service or item is less than the flat dollar copayment, you will pay the Network Providers' discounted charge. A copayment or coinsurance is due at the time a service is provided, or when billed by the provider.

For services provided by a Non-Network Provider:

Any copayment or coinsurance is applied to the lesser of the providers' charge or the usual and customary charge for a service.

The copayment or coinsurance applicable for a scheduled visit with a Network Provider will be collected for each visit, late cancellation and failed appointment.

Deductible: The specified dollar amount of charges incurred for Covered Services, which the Plan does not pay, but a Covered Person or a covered family has to pay first in a plan year. The Plan's payment for those services or items begins after the deductible is satisfied.

For Network Providers, the amount of charges that apply to the deductible are based on the Network Providers' discounted charges, calculated at the time the claim is processed, which may include an agreed upon fee schedule for case rate or withhold arrangements. For Non-Network Providers, the amount of charges that apply to the deductible are the lesser of the providers' charges or the usual and customary charge for a service.

The Plan has an embedded deductible. This means once a Covered Person meets the individual deductible, the Plan begins paying benefits for that person. If two or more members of the family meet the family deductible, the Plan begins paying benefits for all members of the family, regardless of whether each Covered Person has met the individual deductible. However, a Covered Person may not contribute more than the individual deductible toward the family deductible.

Unless prohibited by applicable law, any amounts paid or reimbursed by a third party, including, but not limited to, point of service rebates; manufacturer coupons; manufacturer debit cards or other forms of direct reimbursement to a Covered Person for a product or service, may not apply toward your deductible.

Out-of-Pocket Expenses: You pay the specified copayments/coinsurance and deductibles applicable for particular services, subject to the out-of-pocket limit described below. These amounts are in addition to employee contributions.

Out-of-Pocket Limit: You pay the copayments/coinsurance and deductibles for Covered Services, to the individual or family out-of-pocket limit. Thereafter, 100% of charges incurred are covered under the Plan for all other Covered Services for the rest of the plan year. You pay amounts greater than the out-of-pocket limit if you exceed any visit or day limits.

Non-Network Benefits above the usual and customary charge (see definition of charge) do not apply to the out-of-pocket limit.

Unless prohibited by applicable law, any amounts paid or reimbursed by a third party, including, but not limited to, point of service rebates; manufacturer coupons; manufacturer debit cards or other forms of direct reimbursement to a Covered Person for a product or service, may not apply as an out-of-pocket expense.

You are responsible to keep track of the out-of-pocket expenses. Contact HealthPartners Member Services department for assistance in determining the amount paid by the Covered Person for specific eligible services received. Claims for reimbursement under the out-of-pocket limit provisions are subject to the same time limits and provisions described under the "CLAIMS PROCEDURES" section of the SPD.

Benefit Year: January 1 through December 31.

DEDUCTIBLES AND OUT-OF-POCKET LIMITATIONS

Benefit Year Deductible

Individual Benefit Year Deductible

Network Benefits	Non-Network Benefits
$400	$800

Family Benefit Year Deductible

Network Benefits	Non-Network Benefits
$800	$1,600

The deductibles under the Network Benefits and the Non-Network Benefits are combined.

The Plan has an embedded deductible. This means once a Covered Person meets the individual deductible, the Plan begins paying benefits for that person. If two or more members of the family meet the family deductible, the Plan begins paying benefits for all members of the family, regardless of whether each Covered Person has met the individual deductible. However, a Covered Person may not contribute more than the individual deductible toward the family deductible.

BENEFIT YEAR OUT-OF-POCKET LIMIT

Individual Benefit Year Out-of-Pocket Limit

Network Benefits	Non-Network Benefits
$2,400	$4,800

Family Benefit Year Out-of-Pocket Limit

Network Benefits	Non-Network Benefits
$4,800	$9,600

The out-of-pocket limits under the Network Benefits and the Non-Network Benefits are combined.

Non-Network Benefits above the usual and customary charge (see definition of charge) do not apply to the out-of-pocket limit.

AMBULANCE AND MEDICAL TRANSPORTATION

Network Benefits	Non-Network Benefits
80% of the charges incurred, after you pay the deductible.	80% of the charges incurred, after you pay the Network deductible. Subject to the Network out-of-pocket limit. The amount you pay for these services will be determined based on the requirements of the No Surprises Act and its implementing regulations.

Covered Services:

The Plan covers ground ambulance, fixed wing air ambulance and rotary wing air ambulance for medical emergencies.

The Plan also covers ground ambulance, fixed wing air ambulance and rotary wing air ambulance for non-emergency medical transportation if it meets the Medical Coverage Criteria.

Non-emergency fixed wing air ambulance requires prior authorization.

Covered Services and supplies are based on established medical policies, which are subject to periodic review and modification by the medical directors. The Medical Coverage Criteria and applicable prior authorization requirements are available by logging on to your "*my*HealthPartners" account at healthpartners.com or by calling Member Services.

Not Covered:

- Please refer to the "Medical Benefit Exclusions" section.

AUTISM SERVICES

Network Benefits	Non-Network Benefits
$20 copayment and 100% thereafter per visit. Deductible does not apply.	70% of the charges incurred, after you pay the deductible.

Covered Services:

For children under the age of 18, the Plan covers the diagnosis, evaluations and multidisciplinary assessment of autism spectrum disorders. The Plan covers medically necessary care including, but not limited to, the following:

- Early intensive behavioral and developmental therapy based in behavioral and developmental science, including, but not limited to, all types of applied behavior analysis, intensive early intervention behavior therapy and intensive behavior intervention;
- Neurodevelopmental and behavioral health treatments and management;
- Speech therapy;
- Occupational therapy; and
- Physical therapy.

The diagnosis, evaluation and assessment includes an assessment of the child's developmental skills, functional behavior, needs and capacities. Treatment must be in accordance with an individualized treatment plan prescribed by the Covered Person's treating physician or mental health professional.

The Plan can request an updated treatment plan no more frequently than once every six months, unless we or your attending physician agree earlier review is necessary due to emerging circumstances.

An independent progress evaluation conducted by a mental health professional with expertise and training in autism spectrum disorder and child development must be completed to determine whether progress is being made toward function and generalizable goals, set forth in the treatment plan.

Coverage for physical therapy, occupational therapy and speech therapy are covered under the "Physical Therapy, Occupational Therapy and Speech Therapy" section.

Covered Services and supplies are based on established medical policies, which are subject to periodic review and modification by the medical directors. The Medical Coverage Criteria are available by logging on to your "*my*HealthPartners" account at healthpartners.com or by calling Member Services.

Not Covered:

- Please refer to the "Medical Benefit Exclusions" section.

BEHAVIORAL HEALTH SERVICES

Mental health services

Mental health office visits

Network Benefits	Non-Network Benefits
$20 copayment and 100% thereafter per visit. Deductible does not apply. For family therapy, only one copayment will be charged, regardless of the number of insureds primarily involved in the therapy.	70% of the charges incurred, after you pay the deductible.

Group therapy in an office

Network Benefits	Non-Network Benefits
$20 copayment and 100% thereafter per visit. Deductible does not apply.	70% of the charges incurred, after you pay the deductible.

Mental health outpatient hospital and day treatment services

Network Benefits	Non-Network Benefits
80% of the charges incurred, after you pay the deductible.	70% of the charges incurred, after you pay the deductible.

Doctor on Demand

Network Benefits	Non-Network Benefits
100% of the charges incurred. Deductible does not apply.	Not applicable.

Covered Services:

Covered Services and supplies are based on established medical policies, which are subject to periodic review and modification. The Medical Coverage Criteria are available by logging on to your "*my*HealthPartners" account at healthpartners.com or by calling Member Services.

The Plan covers services for mental health diagnoses as described in the Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM 5) (most recent edition).

The Plan also provides coverage for the initial mental health evaluation of a child, regardless of whether that evaluation leads to a court order for treatment, if the evaluation is ordered by a Minnesota juvenile court.

Outpatient Services, including intensive outpatient and day treatment services.

The Plan covers medically necessary outpatient professional mental health services for evaluation, crisis intervention, and treatment of mental health disorders.

A comprehensive diagnostic assessment will be used as the basis for a determination by a mental health professional, concerning the appropriate treatment and the extent of services required.

Outpatient services covered by the Plan for a diagnosed mental health condition include the following:

- Individual, group, family, and multi-family therapy;
- Medication management provided by a physician, certified nurse practitioner, or physician's assistant;
- Psychological testing services for the purposes of determining the differential diagnoses and treatment planning for patients currently receiving behavioral health services;
- Day treatment and intensive outpatient services in a licensed program;
- Partial hospitalization services in a licensed hospital or community mental health center;
- Psychotherapy and nursing services provided in the home; and
- Treatment for gender dysphoria.

Inpatient services, including mental health residential treatment services.

Network Benefits	**Non-Network Benefits**
80% of the charges incurred, after you pay the deductible.	No coverage.

The Plan covers the following:

- Medically necessary inpatient services in a hospital and professional services for treatment of mental health disorders. Medical stabilization is covered under inpatient hospital services in the "Hospital and Skilled Nursing Facility Services" section; and
- Medically necessary mental health residential treatment services. This care must be prior authorized by HealthPartners and provided by a hospital or residential behavioral health treatment facility licensed by the local state or Department of Health and Human Services.

Services not covered under this benefit include halfway houses, group homes, extended care facilities, shelter services, correctional services, detention services, transitional services, housing support programs, foster care services and wilderness programs.

Substance use disorder (SUD) services

Substance use disorder office visits

Network Benefits	Non-Network Benefits
$20 copayment and 100% thereafter per visit. Deductible does not apply. For family therapy received under the Network Benefits, only one copayment will be charged, regardless of the number of family members primarily involved in the therapy.	70% of the charges incurred, after you pay the deductible.

Substance use disorder outpatient hospital and day treatment services

Network Benefits	Non-Network Benefits
80% of the charges incurred, after you pay the deductible.	70% of the charges incurred, after you pay the deductible.

Doctor on Demand

Network Benefits	Non-Network Benefits
100% of the charges incurred. Deductible does not apply.	Not applicable.

The Plan covers medically necessary services for assessments by a licensed alcohol and drug counselor and treatment of substance use disorders as defined in the Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM 5) (most recent edition).

Outpatient services, including intensive outpatient and day treatment services.

The Plan covers medically necessary outpatient professional services for diagnosis and treatment of substance use disorder. Substance use disorder treatment services must be provided by a program licensed by the local Department of Health and Human Services.Outpatient services covered by the Plan for a diagnosed substance use disorder include the following:

- Individual, group, family, and multi-family therapy provided in an office setting;
- Opiate replacement therapy including methadone and buprenorphine treatment; and
- Day treatment and intensive outpatient services in a licensed program.

Inpatient services.

Network Benefits	Non-Network Benefits
80% of the charges incurred, after you pay the deductible.	No coverage.

Covered Services:

- Medically necessary inpatient services in a hospital or primary residential treatment in a licensed substance use disorder treatment center. Primary residential treatment is an intensive residential treatment program of limited duration, typically 30 days or less;
- Services provided in a hospital that is licensed by the local state and accredited by Medicare; and
- Detoxification services in a hospital or community detoxification facility if it is licensed by the local Department of Health and Human Services.

Not Covered:

- Please refer to the "Medical Benefit Exclusions" section.

BONE-ANCHORED HEARING AIDS (BAHA)

Network Benefits	**Non-Network Benefits**
80% of the charges incurred, after you pay the deductible.	70% of the charges incurred, after you pay the deductible.

Covered Services:

The Plan covers bone-anchored hearing aid (BAHA) equipment.

Bone-anchored hearing aid (BAHA) surgery that meets the Medical Coverage Criteria is covered at the corresponding benefit depending on the type of service provided, such as Outpatient Hospital Services.

Not Covered:

- Please refer to the "Medical Benefit Exclusions" section.

CHIROPRACTIC SERVICES

Network Benefits	**Non-Network Benefits**
80% of the charges incurred, after you pay the deductible.	70% of the charges incurred, after you pay the deductible.

Covered Services:

The Plan covers chiropractic services for rehabilitative care, rendered to diagnose and treat acute neuromusculoskeletal conditions.

Massage therapy which is performed in conjunction with other treatment/modalities by a chiropractor, is part of a prescribed treatment plan and is not billed separately is covered.

Network Benefits and Non-Network Benefits, combined, are limited to 20 visits per plan year.

Not Covered:

- Please refer to the "Medical Benefit Exclusions" section.

CLINICAL TRIALS

Network Benefits	Non-Network Benefits
Coverage level is same as corresponding Network Benefits, depending on the type of service provided such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.	Coverage level is same as corresponding Non-Network Benefits, depending on the type of service provided such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.

Covered Services:

The Plan covers certain routine services if you participate in a Phase I, Phase II, Phase III or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition as defined in the Affordable Care Act. The Plan covers routine patient costs for services that would be eligible under this Plan if the service was provided outside a clinical trial.

Not Covered:

- Please refer to the "Medical Benefit Exclusions" section.

DENTAL SERVICES

Covered Services:

Accidental dental services. The Plan covers dentally necessary services to treat and restore damage done to sound, natural, unrestored teeth as a result of an accidental injury. Coverage is for damage caused by external trauma to face and mouth only, not for cracked or broken teeth which result from biting or chewing. The Plan covers restorations, root canals, crowns and replacement of teeth lost that are directly related to the accident in which the Covered Person was involved. The Plan covers initial exams, x-rays, and palliative treatment including extractions, and other oral surgical procedures directly related to the accident. Subsequent treatment must be initiated within 12 months of the date of the injury and must be related to the accident. The Plan does not cover restoration and replacement of teeth that are not "sound and natural" at the time of the accident.

Full mouth rehabilitation to correct occlusion (bite) and malocclusion (misaligned teeth not due to the accident) are not covered.

When an implant-supported dental prosthetic treatment is pursued, the accidental dental benefit will be applied to the prosthetic procedure. Benefits are limited to the amount that would be paid toward the placement of a removable dental prosthetic appliance that could be used in the absence of implant treatment.

For all accidental dental services, treatment and/or restoration must be initiated within 12 months of the date of the injury. Coverage is limited to the initial course of treatment and/or initial restoration.

Network Benefits	Non-Network Benefits
80% of the charges incurred, after you pay the deductible.	70% of the charges incurred, after you pay the deductible.

Medical referral dental services

Medically necessary outpatient dental services.

The Plan covers certain medically necessary outpatient dental services. Coverage is limited to dental services required for treatment of an underlying medical condition, e.g., removal of teeth to complete radiation treatment for cancer of the jaw, cysts and lesions.

Network Benefits	**Non-Network Benefits**
Coverage level is same as corresponding Network Benefits, depending on the type of service provided such as Office Visits for Illness or Injury or Outpatient Hospital Services.	70% of the charges incurred, after you pay the deductible.

Medically necessary hospitalization and anesthesia for dental care.

Network Benefits	**Non-Network Benefits**
80% of the charges incurred, after you pay the deductible.	No coverage.

The Plan covers certain medically necessary hospitalization and anesthesia for dental care. This is limited to charges incurred by a Covered Person who: (1) is a child under age 5; (2) is severely disabled; (3) has a medical condition, and requires hospitalization or general anesthesia for dental care treatment; (4) is a child between ages 5 and 12 and care in dental offices has been attempted unsuccessfully and usual methods of behavior modification have not been successful; or (5) when extensive amounts of restorative care, exceeding four appointments, are required. Coverage is limited to facility and anesthesia charges. Anesthesia is covered in a hospital or a dental office. Oral surgeon/dentist professional fees are not covered. The following are examples, though not all-inclusive, of medical conditions which may require hospitalization for dental services: severe asthma, severe airway obstruction or hemophilia. Except as listed above, hospitalization required due to the behavior of the Covered Person or due to the extent of the dental procedure is not covered.

Medical complications of dental care.

Network Benefits	**Non-Network Benefits**
Coverage level is same as corresponding Network Benefits, depending on the type of service provided such as Office Visits for Illness or Injury or Outpatient Hospital Services.	70% of the charges incurred, after you pay the deductible.

The Plan covers certain medical complications of dental care. Treatment must be medically necessary care and related to significant medical complications of non-covered dental care, including complications of the head, neck, or substructures.

Oral surgery.

Network Benefits	Non-Network Benefits
Coverage level is same as corresponding Network Benefits, depending on the type of service provided such as Office Visits for Illness or Injury or Outpatient Hospital Services.	70% of the charges incurred, after you pay the deductible.

The Plan covers certain oral surgery. Coverage is limited to treatment of medical conditions requiring oral surgery, such as treatment of oral neoplasm, non-dental cysts, fracture of the jaws and trauma of the mouth and jaws.

Orthognathic surgery benefit.

Network Benefits	Non-Network Benefits
80% of the charges incurred, after you pay the deductible.	70% of the charges incurred, after you pay the deductible.

The Plan covers orthognathic surgery for the treatment of severe skeletal dysmorphia where a functional occlusion cannot be achieved through non-surgical treatment alone and where a demonstrable functional impairment exists. Functional impairments include but are not limited to significant impairment in chewing, breathing or swallowing. Associated dental or orthodontic services (pre- or post- operatively including surgical rapid palatal expansion) are not covered as a part of this benefit.

Treatment of cleft lip and cleft palate.

Network Benefits	Non-Network Benefits
Coverage level is same as corresponding Network Benefits, depending on the type of service provided such as Office Visits for Illness or Injury or Outpatient Hospital Services.	70% of the charges incurred, after you pay the deductible.

The Plan covers certain treatment of cleft lip and cleft palate of a dependent child, to the limiting age in the definition of an "Eligible Dependent", including orthodontic treatment and oral surgery directly related to the cleft. Benefits for individuals up to age 26 for coverage of the dependent are limited to inpatient or outpatient expenses arising from medical and dental treatment that was scheduled or initiated prior to the dependent turning age 19. Dental services which are not necessary for the treatment of cleft lip or cleft palate are not covered. If a dependent child covered under the Plan is also covered under a dental plan which includes orthodontic services, that dental plan shall be considered primary for the necessary orthodontic services. Oral appliances are subject to the same copayment, conditions and limitations as durable medical equipment.

Treatment of temporomandibular disorder (TMD) and craniomandibular disorder (CMD).

Network Benefits	Non-Network Benefits
Coverage level is same as corresponding Network Benefits, depending on the type of service provided such as Office Visits for Illness or Injury or Outpatient Hospital Services.	70% of the charges incurred, after you pay the deductible.

The Plan covers surgical and non-surgical treatment of temporomandibular disorder (TMD) and craniomandibular disorder (CMD), when such care is medically necessary. Dental services which are not required to directly treat TMD or CMD are not covered.

Not Covered:

- Please refer to the "Medical Benefit Exclusions" section.

DIABETIC EQUIPMENT AND SUPPLIES

In order to be covered by this plan, eligible items must be purchased from an approved durable medical equipment vendor. Items purchased from a pharmacy are administered by ProAct Rx.

For more information regarding ProAct Rx, see the "Prescription Drug Coverage" section.

Pumps and pump supplies. These include diabetic insulin pumps, diabetic infusion pumps and infusion pump supplies such as infusion sets, tubing, connectors and syringe reservoirs.

Network Benefits	Non-Network Benefits
80% of the charges incurred, after you pay the deductible, if purchased from an approved vendor.	70% of the charges incurred, after you pay the deductible.

Continuous glucose monitoring system (CGMS), transmitter, sensors and receivers

Network Benefits	Non-Network Benefits
80% of the charges incurred, after you pay the deductible, if purchased from an approved vendor.	70% of the charges incurred, after you pay the deductible.

Covered Services:

The Plan covers physician prescribed medically appropriate and necessary supplies used in the management and treatment of diabetes for Covered Persons with gestational, Type I or Type II diabetes including certain durable diabetic equipment.

Certain items are only covered if your condition meets the Medical Coverage Criteria and obtained through an authorized vendor. For more information on what the Plan covers and any prior authorization requirements, call Member Services or log on to your "*my*HealthPartners" account at healthpartners.com.

Limitations:

- The Plan requires that certain diabetic supplies and equipment be purchased at a pharmacy and are covered by ProAct Rx. For more information regarding ProAct Rx, see the "Prescription Drug Coverage" section.
- Durable medical equipment and supplies must be obtained from or repaired by approved vendors.
- Covered services and supplies are based on established medical policies which are subject to periodic review and modification by the medical directors. The coverage policy for diabetic supplies includes information on our required models and brands. These medical policies (Medical Coverage Criteria) are available by calling Member Services or logging on to your "*my*HealthPartners" account at healthpartners.com.

Not Covered:

- Diabetic supplies including needles, lancets and test strips purchased at a pharmacy or durable medical equipment vendor.
- Replacement or repair of any covered items, if the items are (i) damaged or destroyed by misuse, abuse or carelessness, (ii) lost; or (iii) stolen.
- Duplicate or similar items.
- Labor and related charges for repair of any covered items which are more than the cost of replacement by an approved vendor.
- Batteries for monitors and equipment.
- Sales tax, mailing, delivery charges, service call charges.
- Please refer to the "Medical Benefits Exclusion" section.

DIAGNOSTIC IMAGING SERVICES

Associated with covered preventive services (MRI/CT procedures are not considered preventive)

Network Benefits	**Non-Network Benefits**
100% of the charges incurred. Deductible does not apply.	70% of the charges incurred, after you pay the deductible.

Services for illness or injury

Magnetic resonance imaging (MRI) and computed tomography (CT)

Network Benefits	**Non-Network Benefits**
80% of the charges incurred, after you pay the deductible.	70% of the charges incurred, after you pay the deductible.

All other outpatient diagnostic imaging services

Network Benefits	Non-Network Benefits
80% of the charges incurred, after you pay the deductible.	70% of the charges incurred, after you pay the deductible.

Covered Services:

The Plan covers diagnostic imaging, when ordered by a provider and provided in a clinic or outpatient hospital facility (to see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under "Hospital and Skilled Nursing Facility Services").

Not Covered:

- Please refer to the "Medical Benefit Exclusions" section.

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES

Special dietary treatment for phenylketonuria (PKU) if it meets the Medical Coverage Criteria

Network Benefits	Non-Network Benefits
80% of the charges incurred. Deductible does not apply.	70% of the charges incurred, after you pay the deductible.

Oral amino acid based elemental formula if it meets the Medical Coverage Criteria

Network Benefits	Non-Network Benefits
80% of the charges incurred, after you pay the deductible.	70% of the charges incurred, after you pay the deductible.

All other durable medical equipment, prosthetics, orthotics and supplies

Network Benefits	Non-Network Benefits
80% of the charges incurred, after you pay the deductible.	70% of the charges incurred, after you pay the deductible.

Covered Services:

The Plan covers equipment, supplies and services, as described below. Certain items are only covered if your condition meets the Medical Coverage Criteria. For more information on what the Plan covers and any prior authorization requirements, call Member Services or log on to your "*my*HealthPartners" account at healthpartners.com.

- Durable medical equipment, such as wheelchairs, ventilators, oxygen, oxygen equipment, continuous positive airway pressure (CPAP) devices, hospital beds, and related services.
- Prosthetics, including breast prostheses, artificial limbs and artificial eyes, and related supplies.
- Hair prostheses (wigs) for hair loss resulting from alopecia areata or chemotherapy.
- Orthotics.
- Medical supplies, including splints, surgical stockings, casts and dressings.
- Enteral feedings.
- Special dietary treatment for Phenylketonuria (PKU) and oral amino acid based elemental formula if it is recommended by a physician.

Diabetic equipment and supplies purchased from an approved durable medical equipment vendor are covered under the "Diabetic Equipment and Supplies" section.

In order to be covered by this plan, eligible items must be purchased from an approved durable medical equipment vendor. Items purchased from a pharmacy are administered by another vendor. For more information regarding this vendor, please contact your Employer.

There is no coverage for foot orthotics, except custom molded foot orthotics ordered for individuals diagnosed with diabetes with neurological manifestations and arthropathy and/or ulcer(s) of the lower limbs.

Limitations:

Coverage of durable medical equipment is limited by the following:

- Payment will not exceed the cost of an alternate piece of equipment or service that is effective and medically necessary.
- Hair prostheses (wigs) for hair loss resulting from alopecia areata or chemotherapy/radiation are limited to one per plan year.
- For prosthetic benefits, other than hair prostheses (wigs) for hair loss resulting from alopecia areata or chemotherapy/radiation and oral appliances for cleft lip and cleft palate, payment will not exceed the cost of an alternate piece of equipment or service that is effective, medically necessary and enables Covered Persons to conduct standard activities of daily living.
- The Plan reserves the right to determine if an item will be approved for rental vs. purchase.
- Durable medical equipment and supplies must be obtained from approved vendors.
- Covered Services and supplies are based on established medical policies which are subject to periodic review and modification by the medical directors. The Medical Coverage Criteria are available by calling Member Services, or logging on to your "*my*HealthPartners" account at healthpartners.com.

Not Covered:

Items which are not eligible for coverage include, but are not limited to:

- Replacement or repair of any covered items.
- Duplicate or similar items.
- Labor and related charges for repair of any covered items.

- Sales tax, mailing, delivery charges, service call charges.
- Items which are primarily educational in nature or for hygiene, vocation, comfort, convenience or recreation.
- Communication aids or devices: equipment to create, replace or augment communication abilities including, but not limited to, speech processors, receivers, communication boards, or computer or electronic assisted communication.
- Hearing aids and their fitting. This exclusion does not apply to bone anchored hearing aids or cochlear implants.
- Foot orthotics, except custom molded foot orthotics ordered for individuals diagnosed with diabetes with neurological manifestations and arthropathy and/or ulcer(s) of the lower limbs.
- Eyeglasses, contact lenses and their fitting, measurement and adjustment, except as specifically described in this SPD.
- Household equipment which primarily has customary uses other than medical, such as, but not limited to, exercise cycles, air purifiers, central or unit air conditioners, water purifiers, non-allergenic pillows, mattresses or waterbeds.
- Household fixtures including, but not limited to, escalators or elevators, ramps, swimming pools and saunas.
- Modifications to the structure of the home including, but not limited to, wiring, plumbing or charges for installation of equipment.
- Vehicle, car or van modifications including, but not limited to, hand brakes, hydraulic lifts and car carriers.
- Rental equipment while owned equipment is being repaired by non-contracted vendors, beyond one month rental of medically necessary equipment.
- Other equipment and supplies, including but not limited to assistive devices, that we determine are not eligible for coverage.
- Please refer to the "SERVICES NOT COVERED" section.

EMERGENCY AND URGENTLY NEEDED CARE SERVICES

Urgently needed care services

Network Benefits	**Non-Network Benefits**
$20 copayment and 100% thereafter per visit. Deductible does not apply.	$20 copayment and 100% thereafter per visit. Deductible does not apply. Subject to the Network out-of-pocket limit.

Covered Services:

The Plan covers services for urgently needed care if the services are otherwise eligible for coverage under this SPD.

These are services to treat an unforeseen illness or injury, which are required in order to prevent a serious deterioration in the Covered Person's health, and which cannot be delayed until the next available clinic hours.

Emergency care services

Emergency care in a hospital emergency room, including professional services of a physician

Network Benefits	Non-Network Benefits
$100 copayment and 100% thereafter per emergency room visit. Deductible does not apply. Emergency room copayment is waived if admitted for the same condition within 24 hours.	$100 copayment and 100% thereafter per emergency room visit. Deductible does not apply. Subject to the Network out-of-pocket limit. Emergency room copayment is waived if admitted for the same condition within 24 hours.

Post-stabilization services rendered as part of the visit during which the emergency room services were provided

Network Benefits	Non-Network Benefits
80% of the charges incurred, after you pay the deductible. Non-Network professional fees will be paid at the Network Inpatient Hospital Services Benefit level if the Covered Person is admitted inpatient to a network hospital through the emergency room.	80% of the amount determined under the law, after you pay the deductible. Subject to the Network out-of-pocket limit. The amount you pay for these services will be determined based on the requirements of the No Surprises Act and its implementing regulations.

Covered Services:

These are services to treat: (1) the sudden, unexpected onset of illness or injury which, if left untreated or unattended until the next available clinic or office hours, would result in hospitalization; or (2) a condition requiring professional health services immediately necessary to preserve life or stabilize health. Emergency care includes emergency services as defined in Division BB, Title I, Section 102 of the Consolidated Appropriations Act of 2021.

When reviewing claims for coverage of emergency services, the Plan's medical director will take into consideration (1) whether a reasonable layperson would believe that the circumstances required immediate medical care that could not wait until the next available clinic appointment or be treated through urgent care; (2) the time of day and day of the week the care was provided; and (3) the presenting symptoms, including but not limited to severe pain, to ensure that the decision to reimburse the emergency care is not made solely on the basis of the actual diagnosis.

Not Covered:

- Please refer to the "Medical Benefit Exclusions" section.

GENE THERAPY

Network Benefits	Non-Network Benefits
Coverage level is same as corresponding Network Benefits, depending on the type of service provided such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.	Coverage level is same as corresponding Non-Network Benefits, depending on the type of service provided such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.

Covered Services:

The Plan covers gene therapy treatment that meets the Medical Coverage Criteria.

Limitations:

- Specific types of gene therapy are limited to therapies and conditions specified in the Medical Coverage Criteria.

Not Covered:

- Please refer to the "Medical Benefit Exclusions" section.

HEALTH EDUCATION

Network Benefits	Non-Network Benefits
100% of the charges incurred. Deductible does not apply.	70% of the charges incurred, after you pay the deductible.

Covered Services:

The Plan covers education for preventive services and education for the management of chronic health problems (such as diabetes).

Not Covered:

- Please refer to the "Medical Benefit Exclusions" section.

HOME HEALTH SERVICES

Physical therapy, occupational therapy, speech therapy, respiratory therapy, home health aide services and palliative care

Network Benefits	Non-Network Benefits
80% of the charges incurred, after you pay the deductible.	70% of the charges incurred, after you pay the deductible.

TPN/IV therapy, skilled nursing services, non-routine prenatal/postnatal services, and phototherapy

Network Benefits	Non-Network Benefits
80% of the charges incurred, after you pay the deductible.	70% of the charges incurred, after you pay the deductible.

Each 24-hour visit (or shifts of up to 24-hour visits) equals one visit and counts toward the maximum visits for all other services shown below. Any visit that lasts less than 24 hours, regardless of the length of the visit, will count as one visit toward the maximum visits for all other services shown below. All visits must be medically necessary and benefit eligible.

Maximum visits

Network Benefits	Non-Network Benefits
For all services that meet the home health services requirements described in the SPD, there is a maximum of 180 visits per plan year.	For all services that meet the home health services requirements described in the SPD, there is a maximum of 180 visits per plan year.

Each visit provided under the Network Benefits and Non-Network Benefits, combined, counts toward the maximums shown above.

Routine postnatal well child visits

Network Benefits	Non-Network Benefits
100% of the charges incurred. Deductible does not apply.	70% of the charges incurred, after you pay the deductible.

The routine postnatal well child visits do not count toward the visit limits above.

Covered Services:

The Plan covers skilled nursing services, physical therapy, occupational therapy, speech therapy, respiratory therapy and other therapeutic services, non-routine prenatal and postnatal services, routine postnatal well child visits as described in the Medical Coverage Criteria, phototherapy services for newborns, home health aide services and other eligible home health services when rendered in the Covered Person's home if the Covered Person is homebound (i.e., unable to leave home without considerable effort due to a medical condition). Lack of transportation does not constitute homebound status. For phototherapy services for newborns and high risk pre-natal services, supplies and equipment are included.

The Plan covers total parenteral nutrition/intravenous (TPN/IV) therapy, equipment, supplies and drugs in connection with IV therapy. IV line care kits are covered under Durable Medical Equipment.

You do not need to be homebound to receive total parenteral nutrition/intravenous (TPN/IV) therapy.

The Plan covers palliative care benefits. Palliative care includes symptom management, education and establishing goals for care. The requirement that the Covered Person is homebound will be waived for a limited number of home visits for palliative care, if you have a life-threatening, non-curable condition which has a prognosis of two years or less. Additional palliative care visits are eligible under the home health services benefit if you are homebound and meet all other requirements defined in this section.

Home health services are eligible and covered only when:

- medically necessary; and
- provided as rehabilitative care, terminal care or maternity care; and
- ordered by a physician, and included in the written home care plan.

Limitations:

- Home health services are not provided as a substitute for a primary caregiver in the home or as relief (respite) for a primary caregiver in the home. The Plan will not reimburse family members or residents in the Covered Person's home for the above services.
- A service shall not be considered a skilled nursing service merely because it is performed by, or under the direct supervision of, a licensed nurse. Where a service (such as tracheotomy suctioning or ventilator monitoring or like services) can be safely and effectively performed by a non-medical person (or self-administered), without the direct supervision of a licensed nurse, the service shall not be regarded as a skilled nursing service, whether or not a skilled nurse actually provides the service. The unavailability of a competent person to provide a non-skilled service shall not make it a skilled service when a skilled nurse provides it. Only the skilled nursing component of so-called "blended" services (i.e., services which include skilled and non-skilled components) are covered under the Plan.

Not Covered:

- Please refer to the "Medical Benefit Exclusions" section.

HOME HOSPICE SERVICES

Network Benefits	**Non-Network Benefits**
80% of the charges incurred, after you pay the deductible.	70% of the charges incurred, after you pay the deductible.

Respite care is limited to five days per episode, and respite care and continuous care combined are limited to 30 days.

Covered Services:

Home hospice program. The Plan covers the services described below for Covered Persons who are terminally ill patients and accepted as home hospice program participants. Covered Persons must meet the eligibility requirements of the program and elect to receive services through the home hospice program. The services will be provided in the patient's home, with inpatient care available when medically necessary as described below. Covered Persons who elect to receive hospice services do so in lieu of curative treatment for their terminal illness for the period they are enrolled in the home hospice program.

Eligibility: In order to be eligible to be enrolled in the home hospice program, a Covered Person must: (1) be a terminally ill patient (prognosis of six months or less); (2) have chosen a palliative treatment focus (i.e., emphasizing comfort and supportive services rather than treatment attempting to cure the disease or condition); and (3) continue to meet the terminally ill prognosis as determined by HealthPartners medical director or his or her designee over the course of care. A Covered Person may withdraw from the home hospice program at any time.

Eligible services: Hospice services include the following services provided in accordance with an approved hospice treatment plan.

- **Home health services:**
  - Part-time care provided in the Covered Person's home by an interdisciplinary hospice team (which may include a physician, nurse, social worker, and spiritual counselor) and medically necessary home health services are covered.
  - One or more periods of continuous care in the Covered Person's home or in a setting which provides day care for pain or symptom management, when medically necessary, will be covered.
- **Inpatient services:** The Plan covers medically necessary inpatient services.
- **Other services:**
  - Respite care is covered for care in the Covered Person's home or in an appropriate facility, to give the patient's primary caregivers (i.e., family members or friends) rest and/or relief when necessary in order to maintain a terminally ill patient at home.
  - Medically necessary medications for pain and symptom management.
  - Medically necessary semi-electric hospital beds and other durable medical equipment are covered.
  - Medically necessary emergency and non-emergency care are covered.

Respite care is limited to five days per episode, and respite care and continuous care combined are limited to 30 days.

Terms specific to the home hospice benefit:

Part-time: This is up to two hours of service per day; more than two hours is considered continuous care.

Continuous Care: This is from two to 12 hours of service per day provided by a registered nurse, licensed practical nurse, or home health aide, during a period of crisis in order to maintain a terminally ill patient at home.

Appropriate Facility: This is a nursing home, hospice residence, or other inpatient facility.

Custodial Care Related to Hospice Services: This means providing assistance in the activities of daily living and the care needed by a terminally ill patient which can be provided by a primary caregiver (i.e., family member or friend) who is responsible for the patient's home care.

Not Covered:

- Financial or legal counseling services.
- Housekeeping or meal services in the patient's home.
- Custodial care related to hospice services, whether provided in the home or in a nursing home.
- Any service not specifically described as a Covered Service under this "Home Hospice Services" section.
- Any services provided by a member of the patient's family or resident in the Covered Person's home.
- Please refer to the "Medical Benefits Exclusions" section.

HOSPITAL AND SKILLED NURSING FACILITY SERVICES

Covered Services:

The Plan covers services as described below.

Medical or surgical hospital services

Inpatient hospital services.

The Plan covers the following medical or surgical services, for the treatment of acute illness or injury, which require the level of care only provided in an acute care facility. These services must be authorized by a physician.

Inpatient hospital services include: room and board; the use of operating or maternity delivery rooms; intensive care facilities; newborn nursery facilities; general nursing care, anesthesia, laboratory and diagnostic imaging services, radiation therapy, physical therapy, prescription drugs or other medications administered during treatment, blood and blood products (unless replaced) and blood derivatives, and other diagnostic or treatment related hospital services; physician and other professional medical and surgical services provided while in the hospital, including gender confirmation surgery that meets the Medical Coverage Criteria.

The Plan covers up to 120 hours of services provided by a private duty nurse or personal care assistant who has provided home care services to a ventilator-dependent patient, solely for the purpose of assuring adequate training of the hospital staff to communicate with that patient.

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Network Benefits	**Non-Network Benefits**
80% of the charges incurred, after you pay the deductible.	No coverage.

Each Covered Person's admission or confinement, including that of a newborn child, is separate and distinct from the admission or confinement of any other Covered Person.

Outpatient hospital, ambulatory care or surgical facility services.

The Plan covers the following medical and surgical services, for diagnosis or treatment of illness or injury on an outpatient basis. These services must be authorized by a physician.

Outpatient services include: use of operating rooms, maternity delivery rooms or other outpatient departments, rooms or facilities; and the following outpatient services: general nursing care, anesthesia, laboratory and diagnostic imaging services, radiation therapy, physical therapy, drugs administered during treatment, blood and blood products (unless replaced) and blood derivatives, and other diagnostic or

treatment related outpatient services; physician and other professional medical and surgical services rendered while an outpatient, including gender confirmation surgery that meets the Medical Coverage Criteria.

Network Benefits	Non-Network Benefits
80% of the charges incurred, after you pay the deductible.	70% of the charges incurred, after you pay the deductible.

To see the benefit level for diagnostic imaging services, laboratory services and physical therapy, see benefits under "Diagnostic Imaging Services," "Laboratory Services" and "Physical Therapy".

Skilled nursing facility care.

The Plan covers room and board, daily skilled nursing and related ancillary services for post-acute treatment and rehabilitative care of illness or injury that meets the Medical Coverage Criteria.

Network Benefits	Non-Network Benefits
80% of the charges incurred, after you pay the deductible. Limited to a 120-day maximum per plan year.	No coverage.

Not Covered:

- Please refer to the "Medical Benefits Exclusions" section.

INFERTILITY/FERTILITY SERVICES

Network Benefits	Non-Network Benefits
80% of the charges incurred, after you pay the deductible.	70% of the charges incurred, after you pay the deductible.

Covered Services:

The Plan covers the diagnosis of infertility. These services include diagnostic procedures and tests provided in connection with an infertility evaluation, office visits and consultations to diagnose infertility.

The Plan also covers professional fertility treatment services. These services include medically necessary tests, facility charges, fertility drugs when administered during an office visit and laboratory work related to Covered Services.

Not Covered:

- Infertility/fertility treatment that is not medically necessary; artificial insemination (AI), assisted reproduction (ART), including, but not limited to, intrauterine insemination (IUI), gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), intracytoplasmic sperm injection (ICSI) and/or in-vitro fertilization (IVF), and all charges associated with such procedures; reversal of sterilization; fertility treatment after reversal of sterilization; and sperm, ova or embryo acquisition, retrieval or storage.
- Please refer to the "Medical Benefits Exclusions" section.

LABORATORY SERVICES

Associated with covered preventive services

Network Benefits	Non-Network Benefits
100% of the charges incurred. Deductible does not apply.	70% of the charges incurred, after you pay the deductible.

Prostate-specific antigen (PSA) testing

Network Benefits	Non-Network Benefits
80% of the charges incurred, after you pay the deductible.	70% of the charges incurred, after you pay the deductible.

For illness or injury

Network Benefits	Non-Network Benefits
80% of the charges incurred, after you pay the deductible.	70% of the charges incurred, after you pay the deductible.

Covered Services:

The Plan covers laboratory tests when ordered by a provider and provided in a clinic or outpatient hospital facility (to see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under "Hospital and Skilled Nursing Facility Services").

Effective through the end of the national public health emergency, coverage for the testing of COVID-19 and the associated provider visit will be covered at no cost. Services may be performed by a Network or Non-Network Provider.

Not Covered:

- Please refer to the "Medical Benefits Exclusions" section.

MASTECTOMY RECONSTRUCTION BENEFIT

Network Benefits	Non-Network Benefits
Coverage level is same as corresponding Network Benefits, depending on the type of service provided such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.	Coverage level is same as corresponding Non-Network Benefits, depending on the type of service provided such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.

Covered Services:

The Plan covers reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce symmetrical appearance, prostheses and treatment for physical complications during all stages of mastectomy, including lymphedemas.

Not Covered:

- Please refer to the "Medical Benefits Exclusions" section.

OFFICE VISITS FOR ILLNESS OR INJURY

Office visits

Network Benefits	Non-Network Benefits
$20 copayment and 100% thereafter per visit. Deductible does not apply.	70% of the charges incurred, after you pay the deductible.

Second surgical opinions (contact Member Services)

Network Benefits	Non-Network Benefits
100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.

Convenience clinics

Network Benefits	Non-Network Benefits
$20 copayment and 100% thereafter per visit. Deductible does not apply.	70% of the charges incurred, after you pay the deductible.

Injections administered in a physician's office, other than immunizations

Allergy injections

Network Benefits	Non-Network Benefits
100% of the charges incurred. Deductible does not apply.	70% of the charges incurred, after you pay the deductible.

All other injections

Network Benefits	Non-Network Benefits
100% of the charges incurred. Deductible does not apply.	70% of the charges incurred, after you pay the deductible.

Covered Services:

The Plan covers the following when medically necessary: professional medical and surgical services and related supplies, including biofeedback, of physicians and other health care providers, and blood and blood products (unless replaced) and blood derivatives.

The Plan also covers diagnosis and treatment of illness or injury to the eyes. Where contact or eyeglass lenses are prescribed as medically necessary for the post-operative treatment of cataracts or for the treatment of aphakia, acute or chronic corneal pathology, or keratoconus, the initial evaluation, lenses and fitting are covered under the Plan. Covered Persons must pay for lens replacement beyond the initial pair.

The Plan also provides coverage for the initial physical evaluation of a child if it is ordered by a Minnesota juvenile court.

Services received via video, e-visit or telephone are covered under the "Telehealth/Telemedicine Services" section.

Not Covered:

- Please refer to the "Medical Benefits Exclusions" section.

PEDIATRIC AUTOIMMUNE NEUROPSYCHIATRIC DISORDERS ASSOCIATED WITH STREPTOCOCCAL INFECTIONS (PANDAS) AND PEDIATRIC ACUTE-ONSET NEUROPSYCHIATRIC SYNDROME (PANS) TREATMENT

Network Benefits	Non-Network Benefits
Coverage level is same as corresponding Network Benefits, depending on the type of service provided such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.	Coverage level is same as corresponding Non-Network Benefits, depending on the type of service provided such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.

Covered Services:

The Plan covers treatment for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and for treatment for pediatric acute-onset neuropsychiatric syndrome (PANS). Treatments that must be covered under this section must be recommended by the Covered Person's licensed health care professional and include, but are not limited to, antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, plasma exchange, and immunoglobulin.

Terms specific to this benefit:

Pediatric Acute-onset Neuropsychiatric Syndrome (PANS): This means a class of acute-onset obsessive compulsive or tic disorders or other behavioral changes presenting in children and adolescents that are not otherwise explained by another known neurologic or medical disorder.

Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS): This means a condition in which a streptococcal infection in a child or adolescent causes the abrupt onset of clinically significant obsessions, compulsions, tics, or other neuropsychiatric symptoms or behavioral changes, or a relapsing and remitting course of symptom severity.

Not Covered:

- Please refer to the "Medical Benefits Exclusions" section.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY

Rehabilitative therapy

Network Benefits	Non-Network Benefits
$30 copayment and 100% thereafter per visit, after you pay the deductible.	70% of the charges incurred, after you pay the deductible.

Habilitative therapy

Network Benefits	Non-Network Benefits
$30 copayment and 100% thereafter per visit, after you pay the deductible.	70% of the charges incurred, after you pay the deductible.

Covered Services:

The Plan covers the following physical therapy, occupational therapy and speech therapy services provided in clinic. The Plan also covers physical therapy provided in an outpatient hospital facility. To see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under "Hospital and Skilled Nursing Facility Services."

- Rehabilitative care to correct the effects of illness or injury.
- Habilitative care rendered for congenital, developmental or medical conditions which have significantly limited the successful initiation of normal speech and normal motor development.

Massage therapy which is performed in conjunction with other treatment/modalities by a physical or occupational therapist and is part of a prescribed treatment plan and is not billed separately is covered.

Not Covered:

- Please refer to the "Medical Benefits Exclusions" section.

PREVENTIVE SERVICES

Applicable Definitions:

Routine preventive services are routine healthcare services that include screenings, check-ups and counseling to prevent illness, disease or other health problems before symptoms occur.

Diagnostic services are services to help a provider understand your symptoms, diagnose illness and decide what treatment may be needed. They may be the same services listed as preventive services, but they are being used as diagnostic services. Your provider will determine if these services are preventive or diagnostic. These services are not preventive if received as part of a visit to diagnose, manage or maintain an acute or chronic medical condition, illness or injury. When that occurs, unless otherwise indicated below, standard deductibles, copayments or coinsurance apply.

Covered Services:

Covered Services are based on established medical policies, which are subject to periodic review and modification by the medical or dental directors. The Medical Coverage Criteria are available by logging on to your "*my*HealthPartners" account at healthpartners.com or by calling Member Services.

The Plan covers preventive services which meet any of the requirements under the Affordable Care Act (ACA) shown in the bulleted items below. These preventive services are covered at 100% under the Network Benefits with no deductible, copayments or coinsurance. If a preventive service is not required by the ACA and it is covered at a lower benefit level, it will be specified below. Preventive benefits mandated under the ACA are subject to periodic review and modification. Changes will be effective in accordance with the federal rules. Preventive services mandated by the ACA include:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual;
- Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual;
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
- With respect to women, preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

ACA mandated preventive services are covered as follows:

Routine health exams and periodic health assessments. A physician or health care provider will counsel Covered Persons as to how often health assessments are needed based on age, sex and health status of the Covered Person. This includes screening and counseling for tobacco use and all FDA approved tobacco cessation medications including over-the-counter drugs (as shown in the "Prescription Drug Services" section).

Network Benefits	**Non-Network Benefits**
100% of the charges incurred. Deductible does not apply.	70% of the charges incurred, after you pay the deductible.

Child health supervision services. This includes pediatric preventive services such as newborn screenings, appropriate immunizations, developmental assessments and laboratory services appropriate to the age of the child from birth to 72 months and appropriate immunizations to age 18.

Network Benefits	**Non-Network Benefits**
100% of the charges incurred. Deductible does not apply.	70% of the charges incurred, after you pay the deductible.

Routine prenatal care and exams

Network Benefits	**Non-Network Benefits**
100% of the charges incurred. Deductible does not apply.	70% of the charges incurred, after you pay the deductible.

Routine postnatal care. This includes health exams, assessments, education and counseling relating to the period immediately after childbirth.

Network Benefits	Non-Network Benefits
100% of the charges incurred. Deductible does not apply.	70% of the charges incurred, after you pay the deductible.

Routine screening procedures for cancer. This includes colorectal screening or other cancer screenings recommended by the USPSTF with an A or B rating. "Women's Preventive Health Services" below describes additional routine screening procedures for cancer.

Network Benefits	Non-Network Benefits
100% of the charges incurred. Deductible does not apply.	70% of the charges incurred, after you pay the deductible.

Computed tomography (CT) scans for lung cancer prevention for adults age 18 and older

Network Benefits	Non-Network Benefits
100% of the charges incurred. Deductible does not apply.	70% of the charges incurred, after you pay the deductible.

Professional voluntary family planning services. This includes services to prevent or delay a pregnancy, including counseling and education. Services must be provided by a licensed provider.

Network Benefits	Non-Network Benefits
100% of the charges incurred. Deductible does not apply.	70% of the charges incurred, after you pay the deductible.

Adult immunizations

Network Benefits	Non-Network Benefits
100% of the charges incurred. Deductible does not apply.	70% of the charges incurred, after you pay the deductible.

Women's preventive health services. This includes mammograms, screenings for cervical cancer (pap smears), breast pumps, human papillomavirus (HPV) testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus (HIV) and all FDA approved contraceptive methods as prescribed and provided by a physician, sterilization procedures, education and counseling. For women whose family history is associated with an increased risk for BRCA1 or BRCA2 gene mutations, the Plan covers genetic counseling and BRCA screening without cost sharing, if appropriate and as determined by a physician.

Network Benefits	Non-Network Benefits
100% of the charges incurred. Deductible does not apply.	70% of the charges incurred, after you pay the deductible.

Obesity screening and management. The Plan covers obesity screening and counseling. If you are age 18 or older and have a body mass index of 30 or more, the Plan covers intensive obesity management to help you lose weight. Your primary care physician can coordinate these services.

Network Benefits	Non-Network Benefits
100% of the charges incurred. Deductible does not apply.	70% of the charges incurred, after you pay the deductible.

In addition to any ACA mandated preventive services referenced above, the Plan covers the following eligible services:

Routine eye exams

Network Benefits	Non-Network Benefits
100% of the charges incurred. Deductible does not apply.	70% of the charges incurred, after you pay the deductible.

Routine hearing exams for Covered Persons through age 18

Network Benefits	Non-Network Benefits
100% of the charges incurred. Deductible does not apply.	70% of the charges incurred, after you pay the deductible.

Ovarian cancer surveillance tests for women who are at risk. "At risk for ovarian cancer" means (1) having a family history that includes any of the following: one or more first-degree or second-degree relatives with ovarian cancer, clusters of female relatives with breast cancer or nonpolyposis colorectal cancer; or (2) testing positive for BRCA1 or BRCA2 mutations. "Surveillance tests for ovarian cancer" means annual screening using: CA-125 serum tumor marker testing, transvaginal ultrasound, pelvic examination or other proven ovarian cancer screening tests currently being evaluated by the federal Food and Drug Administration or by the National Cancer Institute.

Network Benefits	Non-Network Benefits
Coverage level is same as corresponding Network Benefit, depending on type of service provided, such as Diagnostic Imaging Services, Laboratory Services, Office Visits for Illness or Injury or Preventive Services.	Coverage level is same as corresponding Non-Network Benefit, depending on type of service provided, such as Diagnostic Imaging Services, Laboratory Services, Office Visits for Illness or Injury or Preventive Services.

Limitations:

- Services are not preventive if received as part of a visit to diagnose, manage or maintain an acute or chronic medical condition, illness or injury. When that occurs, unless otherwise indicated above, standard deductibles, copayments or coinsurance apply.

Not Covered:

- Please refer to the "Medical Benefit Exclusions" section.

SPECIFIED NON-NETWORK SERVICES

Network Benefits	Non-Network Benefits
Coverage level is same as corresponding Network Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury.	See Network Benefits for the services covered.

Covered Services:

The Plan covers the following services, when a Covered Person elects to receive them from a Non-Network Provider, at the same level of coverage the Plan provides when a Covered Person elects to receive the services from a Network Provider:

- Voluntary family planning of the conception and bearing of children.
- The provider visit(s) and test(s) necessary to make a diagnosis of infertility.
- Testing and treatment of sexually transmitted diseases (other than HIV).
- Testing for AIDS and other HIV-related conditions.

Not Covered:

- Please refer to the "Medical Benefits Exclusions" section.

TELEHEALTH/TELEMEDICINE SERVICES

Covered Services:

The Plan covers the following methods of receiving care for services that would be eligible under the Plan if the service were provided in person.

Scheduled telephone visits

Network Benefits	Non-Network Benefits
100% of the charges incurred. Deductible does not apply.	70% of the charges incurred, after you pay the deductible.

E-visits

Access to online care through Virtuwell at virtuwell.com

Network Benefits	Non-Network Benefits
100% of the charges incurred, after you pay the deductible.	Not applicable.

All other e-visits

Network Benefits	Non-Network Benefits
100% of the charges incurred. Deductible does not apply.	70% of the charges incurred, after you pay the deductible.

Doctor on Demand

Network Benefits	Non-Network Benefits
100% of the charges incurred. Deductible does not apply.	Not applicable.

Video visits

Network Benefits	Non-Network Benefits
Coverage level is same as corresponding Network Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.	Coverage level is same as corresponding Non-Network Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.

Definitions:

Telehealth, telemedicine, or virtual care. This is a means of communication between a health care professional and a patient. This includes the use of secure electronic information, imaging, and communication technologies, including:

- interactive audio or audio-video
- interactive audio with store-and-forward technology
- chat-based and email-based systems
- physician-to-physician consultation
- patient education
- data transmission
- data interpretation
- digital diagnostics (algorithm-enabled diagnostic support)
- digital therapeutics (the use of personal health devices and sensors, either alone or in combination with conventional drug therapies, for disease prevention and management)

Services can be delivered:

Synchronously: the patient and health care professional are engaging with one another at the same time; or

Asynchronously: the patient and health care professional engage with each other at different points in time.

Telephone visits. Live, synchronous, interactive encounters over the telephone between a patient and a healthcare provider.

Doctor on Demand. Doctor on Demand is a nationwide telemedicine provider that provides convenience care services. They are accessible to Covered Persons through a smart phone, tablet or web-cam enabled computer. The visit is an interactive video visit. You may request an on demand visit or schedule a visit at your convenience.

E-visit or chat-based visits. Asynchronous online or mobile app encounters to discuss a patient's personal health information, vital signs, and other physiologic data or diagnostic images. The healthcare provider reviews and delivers a consultation, diagnosis, prescription or treatment plan after reviewing the patient's visit information.

Virtuwell®. This is an online service for you to receive a diagnosis and treatment for certain conditions, such as a cold, flu, ear pain and sinus infections. You may access the Virtuwell website at Virtuwell.com.

Video visits. Live, synchronous, interactive encounters using secure web-based video between a patient and a healthcare provider.

Not Covered:

- Please refer to the "Medical Benefits Exclusions" section.

TRANSPLANT SERVICES

Network Benefits	Non-Network Benefits
80% of the charges incurred, after you pay the deductible.	No coverage.

Covered Services:

Prior authorization is required prior to consultation to support coordination of care and benefits.

The Plan covers eligible Transplant Services (as defined below) while you are a Covered Person. Transplants that will be considered for coverage are limited to the following:

- Kidney transplants for end-stage disease.
- Cornea transplants for end-stage disease.
- Heart transplants for end-stage disease.
- Lung transplants or heart/lung transplants for: (1) primary pulmonary hypertension; (2) Eisenmenger's syndrome; (3) end-stage pulmonary fibrosis; (4) alpha 1 antitrypsin disease; (5) cystic fibrosis; and (6) emphysema.
- Liver transplants for: (1) biliary atresia in children; (2) primary biliary cirrhosis; (3) post-acute viral infection (including hepatitis A, hepatitis B antigen e negative and hepatitis C) causing acute atrophy or post-necrotic cirrhosis; (4) primary sclerosing cholangitis; (5) alcoholic cirrhosis; and (6) hepatocellular carcinoma.
- Allogeneic bone marrow transplants or peripheral stem cell support associated with high dose chemotherapy for: (1) acute myelogenous leukemia; (2) acute lymphocytic leukemia; (3) chronic myelogenous leukemia; (4) severe combined immunodeficiency disease; (5) Wiskott-Aldrich syndrome; (6) aplastic anemia; (7) sickle cell anemia; (8) non-relapsed or relapsed non-Hodgkin's lymphoma; (9) multiple myeloma; and (10) testicular cancer.
- Autologous bone marrow transplants or peripheral stem cell support associated with high-dose chemotherapy for: (1) acute leukemias; (2) non-Hodgkin's lymphoma; (3) Hodgkin's disease; (4) Burkitt's lymphoma; (5) neuroblastoma; (6) multiple myeloma; (7) chronic myelogenous leukemia; and (8) non-relapsed non-Hodgkin's lymphoma.
- Pancreas transplants for simultaneous pancreas-kidney transplants for diabetes, pancreas after kidney, living related segmental simultaneous pancreas kidney transplantation and pancreas transplant alone.

To receive Network Benefits, charges for transplant services must be incurred at a designated transplant center.

The transplant-related treatment provided, including the expenses incurred for directly related donor services, shall be subject to and in accordance with the provisions, limitations, maximums and other terms of this SPD.

Medical and hospital expenses of the donor are covered only when the recipient is a Covered Person and the transplant and directly related donor expenses have been prior authorized for coverage. Treatment of medical complications that may occur to the donor are not covered. Donors are not considered Covered Persons, and are therefore not eligible for the rights afforded to Covered Persons under this SPD.

The list of eligible transplant services and coverage determinations are based on established medical policies which are subject to periodic review and modification by HealthPartners medical director.

Terms specific to the transplant benefit:

Autologous: This is when the source of cells is from the individual's own marrow or stem cells.

Allogeneic: This is when the source of cells is from a related or unrelated donor's marrow or stem cells.

Autologous Bone Marrow Transplant: This is when the bone marrow is harvested from the individual and stored. The patient undergoes treatment which includes tumor ablation with high-dose chemotherapy and/or radiation. The bone marrow is then reinfused (transplanted).

Allogeneic Bone Marrow Transplant: This is when the bone marrow is harvested from a donor and stored. The patient undergoes treatment which includes tumor ablation with high-dose chemotherapy and/or radiation. The bone marrow is reinfused (transplanted).

Autologous/Allogeneic Stem Cell Support: This is a treatment process that includes stem cell harvest from either bone marrow or peripheral blood, tumor ablation with high-dose chemotherapy and/or radiation, stem cell reinfusion, and related care. Autologous/allogeneic bone marrow transplantation and high dose chemotherapy with peripheral stem cell rescue/support are considered to be autologous/allogeneic stem cell support.

Designated Transplant Center: This is any health care provider, group or association of health care providers designated by the Plan to provide Transplant Services, supplies or drugs for specified transplants for Covered Persons.

Transplant Services: This is transplantation (including retransplants) of the human organs or tissue listed above, including all related post-surgical treatment, follow-up care and multiple transplants for a related cause. Transplant Services do not include other organ or tissue transplants or surgical implantation of mechanical devices functioning as a human organ, except surgical implantation of an FDA approved Ventricular Assist Device (VAD) or total artificial heart, functioning as a temporary bridge to heart transplantation.

Not Covered:

- Please refer to the “Medical Benefits Exclusions” section.

WEIGHT LOSS SURGERY OR BARIATRIC SURGERY

Network Benefits	Non-Network Benefits
Coverage level is same as corresponding Network Benefits, depending on the type of service provided such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.	Coverage level is same as corresponding Non-Network Benefits, depending on the type of service provided such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.

Covered Services:

Covered Services are based on established medical policies, which are subject to periodic review and modification by the medical directors. The Medical Coverage Criteria are available by logging on to your "*my*HealthPartners" account at healthpartners.com or by calling Member Services.

Not Covered:

- Bariatric surgery re-operations, regardless of the reason.
- Please refer to the "Medical Benefits Exclusions" section.

MEDICAL BENEFIT EXCLUSIONS

In addition to the General Exclusions, limitations or terms specified elsewhere in this SPD, the Plan will not cover charges incurred for any of the following services, except as specifically described in this SPD:

1. Treatment, procedures, services or drugs which are not medically necessary and/or which are primarily educational in nature or for the vocation, comfort, convenience, appearance or recreation of the Covered Person, including skills training.
2. For Network Benefits, treatment, procedures or services which are not provided by a Network Provider.
3. Procedures, technologies, treatments, facilities, equipment, drugs and devices which are considered investigative, or otherwise not clinically accepted medical services. The Plan considers the following transplants to be investigative and does not cover them: surgical implantation of mechanical devices functioning as a permanent substitute for a human organ, non-human organ implants and/or transplants and other transplants not specifically listed in this SPD. While complications related to an excluded transplant are covered, services which would not be performed but for the transplant, are not covered.
4. Rest and respite services and custodial care, except as specified under the "Home Hospice Services" benefit. This includes all services, medical equipment and drugs provided for such care.
5. Halfway houses, group homes, extended care facilities, shelter services, correctional services, detention services, transitional services, housing support programs, foster care services, wilderness programs and any comparable facilities, services or programs.
6. Foster care, adult foster care and any type of family child care provided or arranged by the local state or county.
7. Services associated with non-covered services, including, but not limited to, diagnostic tests, monitoring, laboratory services, drugs and supplies.
8. Services from non-medically licensed facilities or providers and services outside the scope of practice or license of the individual or facility providing the service.
9. Cosmetic surgery, cosmetic services and treatments, including drugs, primarily for the improvement of the Covered Person's appearance or self-esteem, including, but not limited to, augmentation procedures, reduction procedures and scar revision. This exclusion does not apply to services for port wine stain removal and reconstructive surgery.
10. Commercial weight loss programs, exercise programs and weight loss surgery re-operations.

11. Dental treatment, procedures or services not listed in this SPD.
12. Vocational rehabilitation and recreational or educational therapy.
13. Health services and certifications when required by third parties, including for purposes of insurance, legal proceedings, licensure and employment, and when such services are not preventive care or otherwise medically necessary, such as custody evaluations, vocational assessments, reports to the court, court ordered treatment, parenting assessments, risk assessments for sexual offenses, education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) competency evaluations, and adoption studies. However, the Plan will cover the initial examination of a child ordered by a juvenile court.
14. Infertility/fertility treatment that is not medically necessary; artificial insemination (AI), assisted reproduction (ART), including, but not limited to, intrauterine insemination (IUI), gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), intracytoplasmic sperm injection (ICSI) and/or in-vitro fertilization (IVF), and all charges associated with such procedures; reversal of sterilization; fertility treatment after reversal of sterilization; and sperm, ova or embryo acquisition, retrieval or storage.
15. Services related to the establishment of surrogate pregnancy and fees for a surrogate. However, pregnancy and maternity services are covered for a Covered Person under this SPD including a surrogate pregnancy.
16. Vision correction surgeries such as keratotomy and keratorefractive surgeries, including LASIK surgery, except as specifically described in the Medical Coverage Criteria.
17. Eyeglasses, contact lenses and their fitting, measurement and adjustment, except as specifically described in this SPD.
18. Communication aids or devices: equipment to create, replace or augment communication abilities including, but not limited to, speech processors, receivers, communication boards or computer or electronic assisted communication.
19. Hearing aids and their fitting. This exclusion does not apply to bone anchored hearing aids cochlear implants.
20. Medical Food. Enteral feedings, unless they are the sole source of nutrition used to treat a life-threatening condition, nutritional supplements, over-the-counter electrolyte supplements and infant formula, except as specified in this SPD. This exclusion does not apply to oral amino acid based elemental formula or other items if they meet the Medical Coverage Criteria.
21. Charges for sales tax.
22. Services provided by a family member of the Covered Person, or a resident in the Covered Person's home.
23. Religious counseling, marital/relationship counseling and sex therapy.
24. Private duty nursing services.
25. Services that are rendered to a Covered Person, who also has other primary insurance coverage for those services and who does not provide the Plan the necessary information to pursue coordination of benefits, as required under the Plan.
26. The portion of a billed charge for an otherwise Covered Service by a provider, which is in excess of the usual and customary charges, or which is either a duplicate charge for a service or charges for a duplicate service.
27. Charges for services (a) for which a charge would not have been made in the absence of insurance or medical plan coverage, or (b) which the Covered Person is not legally obligated to pay, and (c) from providers who waive copayment, deductible and coinsurance payments by the Covered Person.
28. Travel and lodging incidental to travel, regardless if it is recommended by a physician and any travel billed by a provider.
29. Health club memberships.
30. Massage therapy for the purpose of a Covered Person's comfort or convenience.
31. Replacement of prescription drugs, medications, equipment and supplies due to loss, damage or theft.
32. Autopsies.

33. Charges incurred for transplants provided by a facility that is not a designated transplant center.
34. Accident related dental services if treatment is (a) provided to teeth which are not sound and natural, (b) to teeth which have been restored, (c) initiated beyond 12 months from the date of the injury, or (d) received beyond the initial treatment or restoration.
35. Nonprescription (over-the-counter) drugs or medications, including, but not limited to, vitamins, supplements, homeopathic remedies and non-FDA approved drugs.
36. Charges for elective home births.
37. Professional services associated with substance use disorder intervention. A "substance use disorder intervention" is a gathering of family and/or friends to encourage a person covered under this SPD to seek substance use disorder treatment.
38. Treatment, procedures, or services or drugs which are provided when you are not covered under this Plan.
39. Care that is not rehabilitative in nature and medically necessary for the diagnosis and/or treatment of acute neuromusculoskeletal conditions.
40. Services provided by naturopathic providers.
41. Items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
42. Non-medical administrative fees and charges including, but not limited to, medical record preparation charges, appointment cancellation fees, after hours appointment charges, and interest charges.
43. Medical cannabis.
44. All prescription drugs, medications or pharmacy items other than those administered during an office visit, during an emergency room or urgent care visit, an outpatient hospital visit or an inpatient stay or unless otherwise specified in this SPD.
45. Drugs that are newly approved by the FDA until they are reviewed and approved by HealthPartners Pharmacy and Therapeutics Committee.
46. Charges for phone, data, software or mobile applications/apps unless specifically described as covered in the Medical Coverage Criteria for the device or service.
47. Hospital services for items for personal convenience, such as television rental.
48. Acupuncture.
49. Oral surgery to remove wisdom teeth.
50. Medication therapy disease management consultation.
51. Routine hearing exams for Covered Persons age 19 and over.
52. Foot orthotics, except custom molded foot orthotics ordered for individuals diagnosed with diabetes with neurological manifestations and arthropathy and/or ulcer(s) of the lower limbs.
53. Health services necessitated by attempting to commit or committing a felony, or engagement in an illegal occupation.
54. Charges or benefits that are provided for or paid by a program of the Federal, State or City Government, including Medicare, CHAMPUS, and statutory disability benefits.

The above listing is not an all-inclusive listing of services not covered by the Plan. It is only representative of the types of services and supplies for which no payment is made by the Plan.

PRESCRIPTION DRUG COVERAGE

The Plan has entered an agreement with ProAct Rx. Under that agreement, ProAct Rx will provide retail and mail order prescription drugs through its network of pharmacies. Pharmacies that are members of that network are referred to in this section as Preferred Providers.

Information regarding this program (including your Plan identification card) will be sent to you when you first become eligible under the Plan.

Payment of Benefits (Retail Pharmacy Program)

When a Covered Person incurs an expense for prescription drugs at a Preferred Provider Pharmacy, benefits are payable only for drugs requiring a written prescription executed by a Physician and dispensed by a licensed pharmacist.

Each plan participant will initially receive personal identification cards to be used for obtaining prescriptions at participating pharmacies. If you lose your card or need an additional card, you may request a replacement from the Plan Administrator.

The procedure for a Covered Person to obtain Prescription Drug Benefits from a participating pharmacy is:

- Present the identification card to the pharmacist with the prescription.
- Verify and sign the claim voucher prepared by the pharmacist.
- Pay the pharmacist the co-payment listed below. Your payment at the pharmacist will be a 15% coinsurance payment subject to the minimums listed below:
    - Generic drugs $ 5.00
    - Brand name drugs $20.00 (formulary)

      $35.00 (non-formulary)

You may receive up to a 90-day supply of generic and brand name drugs at contracted 90-day Rx retail pharmacies subject to 15% coinsurance payment with a $10 minimum co-pay for generic and $40 or $70 minimum co-pay for brand name drugs.

You may purchase certain over-the-counter (OTC) medications subject to 15% coinsurance with a minimum generic co-pay of $5. To do so, you must present a prescription from your doctor for the OTC drugs to be covered.

Specialty Drugs. All specialty drug prescriptions must be filled through ProAct Rx's Specialty Drug Program (Noble Pharmacy). You cannot purchase specialty drugs through any other source. There is a month supply limit on specialty drugs. Any standard ancillary supplies for specialty drugs, such as syringes and alcohol swabs, are included at no extra charge.

You can find out if a particular drug is in the Plan's formulary by contacting the Plan Administrator. You can also go online to www.proactrx.com for more information about the Plan's formulary.

The pharmacist submits your claim to ProAct Rx for you. There should be no additional paperwork for you to handle.

For purposes of calculating the applicable co-payment amount, a prescription shall be deemed to be a 34-day supply of any drug.

Payment of Benefits (Mail Order Program)

Covered Persons may also obtain discounted maintenance prescription drugs through a mail order program. Maintenance drugs are those medications taken on a long-term basis (more than 30 days) for illnesses such as ulcers, diabetes, arthritis, and hypertension. These drugs are available in a 90-day supply.

The information packet distributed by the Plan Administrator contains instructions to order prescription drugs through the mail. The Plan Administrator can also provide mail order packets if you need them.

To order by mail, you must complete a form and send it with your prescription and payment. Your doctor should write the prescription allowing for a three (3) month refill quantity.

You should allow 10 days to two weeks for processing and delivery of your prescription drugs by mail.

The co-payment for a 90-day supply of maintenance drugs will be a 15% coinsurance payment subject to the minimums listed below:

- Generic drugs $10.00
- Brand name drugs $40.00 (formulary)

  $70.00 (non-formulary)

As noted previously, you can find out if a particular drug is in the Plan's formulary by contacting the Plan Administrator or by going online to www.proactrx.com.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

The Plan established a HRA (a notional bookkeeping account) for you. If required by your collective bargaining or participation agreement, your employer will fund a specified amount per hour on a monthly basis to your HRA to be used for eligible expenses as outlined below.

HRA Plan

The Board of Trustees established this Health Reimbursement Arrangement (HRA) as a feature of the Plan, effective April 1, 2022 (the "Effective Date") for claims first incurred on and after January 1, 2022. Capitalized terms used in this HRA Plan, if not otherwise defined in the combined Plan Document and Summary Plan Description (the "SPD"), will have the meanings set forth below.

The HRA is intended to permit a Covered Individual to obtain reimbursement of Medical Care Expenses on a non-taxable basis from the HRA Account. This Plan will be available to active Eligible Employees and Retirees who meet the eligibility requirements found below.

Legal Status

This HRA Plan feature is intended to qualify as an employer-provided medical reimbursement arrangement under Internal Revenue Code (the "Code") §§ 105 and 106 and regulations issued thereunder, and as a Health Reimbursement Arrangement as defined under IRS Notice 2002-45 and will be interpreted to accomplish that objective.

The Medical Care Expenses reimbursed under the HRA Plan are intended to be eligible for exclusion from gross income under Code § 105(b).

Definitions Applicable to the HRA Plan

Benefits. The reimbursement benefits for Medical Care Expenses as defined below.

Contributing Employer. An employer that has signed a collective bargaining agreement or participation agreement requiring contributions to the HRA Account.

Covered Individual. An Eligible Employee, Retiree, and Spouse and Dependent of those individuals.

Dependent. As defined in the Definitions section of the SPD.

Employee or Eligible Employee. An Employee or Retiree eligible to participate in this portion of the Plan, as provided in the Eligibility to Participate Section below.

HRA or Health Reimbursement Arrangement. A health reimbursement arrangement as defined in IRS Notice 2002-45.

HRA Account. The HRA Account described in the Establishment of Account Section.

Medical Care Expenses. Expenses as defined in the Eligible Medical Care Expenses Section.

Period of Coverage. The HRA Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it will mean the portion of the Plan Year following the date participation commences, as described in Eligibility Section; and (b) for Employees who terminate participation, it will mean the portion of the Plan Year prior to the date the Eligible Employee's participation in the Plan terminates.

Plan. The Heat and Frost Insulators Local 34 Health & Welfare Plan, as set forth herein and as amended from time to time, including this HRA Section.

Plan Manager. The Plan has contracted with HealthPartners to administer the HRA Account Plan. HealthPartners has full discretionary authority to act on behalf of the Board of Trustees, except with respect to appeals, for which the Board of Trustees has the full authority to act, as described in the SPD.

Retiree. An eligible Retiree who is covered under the Plan's Limited Retiree Coverage and has a balance in their HRA Account.

HRA Plan Year. The calendar year (i.e., the 12-month period commencing January 1 and ending on December 31), except in the case of a short Plan Year representing the initial Plan Year or where the Plan Year is being changed. In such case, the Plan Year will be the entire short Plan Year.

Eligibility to Participate in HRA Plan

A Covered Individual is eligible to participate in this feature of the Plan if they are:

- An Eligible Employee who is member of Local 34 or has previously been an Eligible Employee and have any funds available in their HRA Account that have not otherwise been forfeited.

- A Non-Bargaining Unit Employee if their Employer has signed a Participation Agreement requiring HRA contributions.
- A Retiree is eligible to participate in this HRA Plan if:
    - They are currently a Retiree covered under the Retiree Coverage provisions of the Plan, and
    - They have an HRA Account balance.

Establishment of Account

The Plan Manager will establish and maintain an HRA Account with respect to each Eligible Employee but will not create a separate fund or otherwise segregate assets for any individual participant for this purpose. The HRA Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and available reimbursement amounts from the Trust.

- *Crediting of Accounts.* An Employee's HRA Account will be credited at the end of each month with an amount equal to the applicable rate specified in the Contributing Employers collective bargaining agreement or Participation Agreement with the Plan, which has been actually received by the Plan.

- *Debiting of Accounts*. An Employee's or Retiree's HRA Account will be debited during each Period of Coverage for all applicable reimbursements, recordkeeping expenses and those other plan administrative expenses charged to the account by the Board of Trustees.

- *Available Amount.* The amount available for reimbursement of Medical Care Expenses is the amount credited to the Employee's or Retiree's HRA Account reduced by prior reimbursements and deductions for administrative expenses.

Carryover of Accounts

Any unused amounts in an Employee's or Retiree's HRA Account can be carried over from one HRA Plan Year to the next.

Termination of Participation – Eligible Employee

An Employee will cease to be an Eligible Employee in this HRA Plan upon the earlier of:

- The termination of this HRA Plan and/or the Plan in general; or
- The date on which the Employee ceases (because of retirement, termination of employment, layoff, reduction in hours, or any other reason) to be an Eligible Employee, provided that eligibility may continue beyond such date for purposes of COBRA Coverage as provided below or under the Plan's Limited Retiree Coverage provisions.

Reimbursements from the HRA Account after termination of participation will be made pursuant to Reimbursements after Termination Section (relating to a run-out period for submitting claims incurred prior to termination, relating to COBRA and reimbursement for Excepted Health Benefits).

Forfeiture of HRA Account Balance

An Eligible Employee will forfeit their HRA Account Balance (Active or Retiree) if the Employee suffers a break in coverage under this Plan of more than one year. A break in coverage for purposes of forfeiture of an HRA Account Balance means the Employee has no coverage of any kind (Active, Self-Pay, COBRA or Retiree) under the Plan for a year or more.

Termination of Participation – Retiree

A Retiree will cease to be an eligible Retiree in this HRA Plan upon the earlier of:

- The termination of this HRA Plan and/or the Plan in general; or
- The date on which the Retiree exhausts their balance in their HRA Account.

Retirees will be able to spend-down the HRA Account they accrued after they reach age 65 as long as they maintain a balance sufficient to pay any administrative expenses.

FMLA and USERRA Leaves of Absence

Notwithstanding any provision to the contrary in this Plan, if an Eligible Employee goes on a qualifying leave under the FMLA or USERRA, then to the extent required by the FMLA or USERRA, as applicable, the Plan will continue to maintain the Eligible Employee's Benefits on the same terms and conditions as if the Eligible Employee were still an active Employee.

Benefits Offered

When an Employee becomes covered in accordance with the terms of the Plan, and if the applicable collective bargaining agreement requires contributions to the HRA portion of the Plan, an HRA Account will be established for such Employee to receive Benefits in the form of reimbursements for Medical Care Expenses.

In no event will Benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Medical Care Expenses.

An Employee will have the option to use their HRA Account for reimbursement of their eligible Medical Care Expenses while they are either an Eligible Employee or an eligible Retiree, as long as they also continue to have a positive HRA Account balance and cover all administrative expenses.

Employer Contributions Only

- *Employer Contributions.* The Employer funds the full amount of the HRA Account. The Board of Trustees may allocate earnings to HRA accounts on the last day of the year, based on balances on that date. There are no Eligible Employee contributions for Benefits under the Plan.

- *No Funding under Cafeteria Plan.* Under no circumstances will the Benefits be funded with salary reduction contributions, employer contributions over which an Employee exercises control (e.g., flex credits) or otherwise under a cafeteria plan, nor will salary reduction contributions or such employer contribution be treated as Employer contributions to the HRA feature of the Plan.

Funding This HRA Plan Feature

All the amounts payable under this HRA Plan will be paid from the general assets of the Trust. Nothing herein will be construed to require the Board of Trustees to maintain any fund or to segregate any amount for the benefit of any Employee, and no Employee or other person will have any claim against, right to, or security or other interest in any fund, account or asset of the Trust from which any payment under this Plan may be made, except for benefits properly payable during the existence of the HRA plan feature. The HRA accounts are not vested benefits. HRA accounts are subject to revision or elimination by the Board of Trustees.

Eligible Medical Care Expenses

Under the HRA Account, a Covered Individual may receive reimbursement for Medical Care Expenses that are incurred under either this Plan during a Period of Coverage or, if not Incurred while a Participant in this Plan, are Incurred while covered under another form of group medical insurance.

- *Incurred.* A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is paid by the Covered Individual. Medical Care Expenses incurred before a Covered Individual first becomes covered by the Plan are not eligible.

- *Medical Care Expenses Generally.* "Medical Care Expenses" means expenses incurred by a Covered Individual for medical care, as defined in Code § 213(d) (including, for example, amounts for certain Hospital bills, doctor and dental bills and prescription drugs). Reimbursements paid for Medical Care Expenses incurred by a Covered Individual will be charged against the Employee's or Retiree's HRA Account. See the examples of benefits eligible and ineligible for reimbursement at the end of this HRA Plan section.

- *Cannot Be Reimbursed or Reimbursable from Another Source.* Medical Care Expenses can only be reimbursed to the extent that the Covered Individual incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through other insurance, including any other accident or health plan (see below if the other health plan is a Health FSA). If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Health Insurance Plan imposes co-payment or deductible limitations), the HRA Account can reimburse the remaining portion of such Expense if it otherwise meets the requirements for reimbursement.

Reimbursement Procedures with HealthPartners

Manual claims submission. To receive reimbursement, you must submit a claim to your HRA for payment consideration. All claims must include a completed Health Care Expense Claim Form, including any required supporting documentation. Health Care Expense Claim Forms can be obtained online at healthpartners.com or by calling Member Services. Claims are paid based on the amount initially submitted. If the amount of the original claim later changes you must notify HealthPartners so that the claim can be adjusted.

To receive reimbursement from your HRA, claims may be submitted in one of the following ways:

- **Mobile –** Download the myHP app to submit a Health Care Expense Claim and supporting documents.
- **Online –** Log on to your account at healthpartners.com.
- **Fax** a claim form and supporting documentation to HealthPartners at 952-883-5026 or 877-624-2287; or
- **Mail** a claim form and supporting documentation to HealthPartners at:

  HealthPartners Service Center
  CDHP – Mail Route 21104T
  P.O. Box 297
  Minneapolis, MN 55440-0297

Supporting documentation includes at least one of the following:

- Explanation of Benefits– the statement you receive each time a claim is submitted to your health plan.
- An itemized statement from the provider. The statement must show the provider name and address, patient name, date of service(s), description of service(s), and itemized charges.

NOTE: Your orthodontic care will be reimbursed as paid up to your election amount in your HRA. You will need to send in proof of payment with the completed claim form. The payment must be made during the plan year.

Claims paid using HRA funds will be paid directly to the Covered Employee. You pay your provider's bill when it arrives.

The minimum reimbursement from your HRA is $20 for the claims that you submit to your HRA for payment consideration. If your claim for eligible expenses is less than $20 it will be considered an incomplete claim. Your claim will be considered complete and will be paid to you when your requested reimbursements for eligible expenses reach $20. If your remaining election is less than $20, the minimum reimbursement will be the balance of your remaining election.

You will be notified when your HRA balance reaches zero. At that time, you will be given your appeal options in the event that you believe that the determination was not correct. However, you will not be further notified, for the remainder of the plan year, that your account balance has reached zero. If, at any time, you have questions about your account balance, please call Member Services at 952-883-7000 or 866-443-9352.

If it is later determined that you received an overpayment or a payment was made in error, the Plan reserves the right to require a refund or to offset future reimbursement equal to the overpayment or erroneous payment.

You must submit your claims within the benefit year in which they are incurred or by June 30th of the following benefit year to receive reimbursement. For example, any claim incurred in 2022 must be submitted by June 30, 2023, to be eligible for reimbursement.

Reimbursements after Termination; COBRA

When an Eligible Employee ceases to be a Participant, the Employee will not be able to receive reimbursements for Medical Care Expenses incurred after their participation terminates (with the exception of the Employee retiring and having an HRA balance available). However, such Employee (or the Employee's estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to termination of participation, provided that the Employee (or the Employee's estate) files a claim within six months of the termination of their participation.

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, the Employee and their Spouse and Dependents (Qualified Beneficiaries), whose coverage terminates under the HRA Account because of a COBRA qualifying event, will be given the opportunity to continue to receive reimbursement the same as if they had under the HRA Account the day before the qualifying event for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA). However, in the event that such coverage is modified for all similarly situated non-COBRA Participants prior to the date continuation coverage is elected, Qualified Beneficiaries will be eligible to continue the same coverage that is provided to similarly situated non-COBRA Participants. Employee's and their Spouse and Dependents should consult the COBRA provisions of the SPD to determine if they are eligible for COBRA continuation coverage.

Coordination of Benefits; Health FSA to Reimburse First

Benefits under this Plan are intended to pay benefits solely for Medical Care Expenses not previously reimbursed or reimbursable elsewhere. To the extent that an otherwise eligible Medical Care Expense is payable or reimbursable from another source, that other source will pay or reimburse prior to payment or reimbursement from this Plan. Without limiting the foregoing, if the Employee's Medical Care Expenses are covered by both this Plan and by a Health FSA, then this Plan is not available for reimbursement of such Medical Care Expenses until after amounts available for reimbursement under the Health FSA have been exhausted.

Procedure If Benefits Are Denied Under This Plan

If a claim for reimbursement under this Plan is wholly or partially denied, claims will be administered in accordance with the claim procedure set forth in the SPD. The Board of Trustees acts on behalf of the Plan with respect to appeals.

Reliance on Covered Individual

The Board of Trustees may rely upon the information submitted by a Covered Individual as being proper under the Plan and will not be responsible for any act or failure to act because of a direction or lack of direction by a Covered Individual.

GENERAL PROVISIONS

Expenses

The Plan will pay the expenses of administering the HRA Plan via an annual January deduction from each Eligible Employee's HRA Account to cover the coming benefit year's administrative expenses. As of adoption of the HRA Plan, the monthly administrative fee is $4.75 per month providing for an annual administrative fee of $57.00 (for 2022, the fee is pro-rated to nine (9) months). The trustees reserve to increase or decrease the monthly administrative fee should they deem it necessary. If Eligible Employees do not have a sufficient balance in January to cover the coming benefit year expenses, their account balance will go negative until such time as incoming contributions are first sufficient to pay the outstanding administrative fee.

No Guarantee of Tax Consequences

Neither the Board of Trustees nor the Employers makes any commitment or guarantee that any amounts paid to or for the benefit of an Employee or Retiree under this Plan will be excludable from the Employee's or Retiree's gross income for federal state or local income tax purposes. It will be the obligation of the Employee or Retiree to determine when each payment under this Plan is excludable from the Employee's or Retiree's gross income for federal, state and local income tax purposes, and to notify the Board of Trustees if the Employee or Retiree has any reason to believe that such payment is not so excludable.

Indemnification of Trust and Plan

If any Employee or Retiree receives one or more payments or reimbursements under this Plan on a tax-free basis, and such payments do not qualify for such treatment under the Code, such Employee or Retiree will indemnify and reimburse the Trust for any liability it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

Non-Assignability of Rights

The right of any Employee or Retiree to receive any reimbursement under this Plan will not be alienable by the Employee or Retiree by assignment or any other method and will not be subject to claims by the Employee's or Retiree's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

Eligible HRA Benefits

The HRA will reimburse any qualified medical care expense under IRS Code §213(d) incurred during a period of coverage. The following expenses are eligible for reimbursement in accordance with the rules and procedures in this HRA Plan. However, this is not intended to be an all-inclusive list. Other expenses not listed here may be reimbursable.

• Acupuncture	• Oxygen and Oxygen Equipment
• Ambulance	• Physiotherapist Services
• Artificial Limb	• Podiatrist Services
• Bandages	• Postnatal Treatments
• Birth Control Pills	• Practical Nurse Medical Services
• Braille Books and Magazines	• Pregnancy Test Kit
• Contact Lenses	• Prescription Medicines
• Crutches	• Prosthesis
• Dental Treatment	• Psychiatrist, Psychoanalyst, Psychologist Services
• Dental X-rays	• Psychotherapy
• Dentures	• Qualified Long-Term Care Insurance Premiums (up to certain limits)
• Diagnostic Devices	• Registered Nurse Services
• Eyeglasses and Surgery	• Special School Costs for the Handicapped
• Fertility Enhancement	• Stop Smoking Programs
• Guide Dog	• Telephone or TV Equipment to Assist the Hard-of-Hearing
• Hearing Aids and Batteries	• Therapy Equipment
• Hospital Bills	• Transportation Expenses (relative to health care)
• Hydrotherapy	• Vaccines
• Insurance premiums for COBRA, Medicare or self-payments for coverage	• Vasectomy
• Lodging (away from home for outpatient care)	• Vitamins (if prescribed)
• Obstetrician Services	• Weight-Loss Program
• Ophthalmologist, Optician, Optometrist Services	• Wig
• Oral Surgery	• Wheelchair
• Orthopedic Shoes	• X-rays
• Over-the-Counter Medications (if prescribed by a Physician, doctor or surgeon)	

Non-Reimbursable HRA Expenses

"Qualified Medical Care Expenses" will not include the following expenses (not an exhaustive list):

• Athletic, Fitness, or Health Club Membership (unless prescribed by a physician)	• Massage Therapy (unless prescribed)
• Automobile Insurance Premium (allocable to medical coverage)	• Maternity Clothes
• Boarding School Fees	• Premiums for health insurance for individual or group policies other than the Plan
• Bottled Water	• Scientology Counseling
• Commuting Expenses of a Disabled Person	• Social Activities
• Cosmetic Surgery and Procedures	• Special Foods or Beverages
• Cosmetics, Hygiene Products, and Similar Items	• Specially Designed Car for the Handicapped (other than an autoette or special equipment)
• Diaper Service	• Swimming Pool
• Domestic Help	• Travel (for general health improvement)
• Funeral, Cremation, or Burial Expenses	• Voluntary Abortion Expenses
• Health Programs offed by Resort Hotel, Health Clubs, and Gyms	• Weight Loss Programs (for general health)
• Illegal Operations and Treatments	• Any item not considered “Medical Care” under IRC Section 213

DENTAL BENEFITS

The Plan covers the dental services and supplies shown in the following Dental Schedule of Benefits provided the services are necessary for the proper care of the patient's condition and meet accepted standards of dental practice, and the fees for such don't exceed the Usual and Customary Charge. This coverage is for the services of a dentist, dental hygienist (working under the supervision of a dentist) or for an oral surgeon, and dental appliances as specified.

The Plan has entered into a preferred provider arrangement with Delta Dental of Minnesota. As with the medical benefits network, you have the choice to use any provider you wish, whether that provider is in or out of the network. Delta Dental offers Plan participants its network of dentists who will provide quality dental care to you and your family. Those dentists have agreed to become part of the network in exchange for charging lower prices for the services they provide. As a result, when you receive services from a network member, your coinsurance will likely be less. You may request a list of network members from the Union or Plan Administrator, or you can ask your dentist if he or she is a network provider.

Benefits will be payable at the Covered Percentages and to the maximums shown in the Schedule of Benefits, after satisfaction of the appropriate deductible amount.

Expense Category	Plan Benefit
Deductible	$25 per benefit year
Maximum Benefit Orthodontia All Other Services *Does not apply to non-cosmetic orthodontia benefits for Dependents under age 19. **Does not apply to Dependents under age 19.	 $1,500 per lifetime** $1,500 per benefit year***
Routine Preventive and Diagnostic	100% (no Deductible) (does not apply toward $1,500 benefit year limit for dependents under age 19)
Regular and Special Restorative	80% following the Deductible
Prosthetics and Dental Implants	80% following the Deductible
Orthodontia (Dependent child only)	50% (no Deductible)

Routine Preventive and Diagnostic Services

Preventive and diagnostic services include the following:

1. Routine periodic exams up to two per benefit year and bitewing x-rays once per benefit year;
2. Full mouth x-rays (once each 3 years unless special need is shown);
3. Dental prophylaxis up to two per benefit year;
4. Topical fluoride once per benefit year.

Regular and Special Restorative Services

Regular and special restorative services include the following:

1. Emergency treatment for relief of pain;

2. Amalgam, preformed crowns, synthetic, porcelain, plastic, and composite restorations;

3. Routine oral surgery, tooth removal and alveolectomy, including pre- and post-operative care;

4. Endodontics, including pupal therapy and root canal fillings;

5. Gold restorations (when another material cannot be used);

6. Non-surgical periodontics necessary for treatment of disease of the gums and gingiva;

7. Surgical periodontics: the surgical procedures necessary for the treatment of diseases of the gingiva (gums);

8. All other oral surgery, not heretofore mentioned;

9. Sealants for children under the age of 15 when applied in a dentist's office.

Prosthetics and Dental Implants

Prosthetics include the following services and supplies:

1. Bridges, partial dentures, and crowns when used as abutments to a bridge.

2. Replacement of an existing dental appliance will not be provided more often than once in any five year period, and then only in the event the existing appliance is not and cannot be made satisfactory. This five-year period will be measured from the date on which the appliance was last supplied, whether under this Plan or not. Services which are necessary to adjust an appliance to make it satisfactory according to accepted dental standards, and the patient's condition will be considered eligible expenses. The term "existing" is intended to include an appliance that was placed at the inception of the five-year period but which for any reason whatsoever is no longer in the possession of the patient.

No coverage is provided for replacement of misplaced, lost, or stolen dental prosthetic devices.

Dental Implants include implantation of artificial material into or onto soft tissue or bone; related hospital charges; and procedures and fixtures associated with fitting the dental implants.

Orthodontics

Orthodontic benefits as described in the Schedule of Benefits are payable only for Dependent children under age 19 and unmarried dependent children age 19 to age 23, provided they are full-time students. The specified percentage of the Usual and Customary Charge will be paid for the following services and supplies:

1. Services and supplies necessary for the correction of malocclusion of the teeth;

2. Orthodontic appliances.

Alternative Treatment Plans

In all cases in which there are alternative plans of treatment carrying different treatment costs, payment will be made only for the applicable percentage of the least costly course of treatment with the balance of the treatment costs remaining the responsibility of the Plan Member.

Pre-determination of Benefits

In order to prevent misunderstanding regarding the amount of coverage provided by this Plan, should extensive dental work be required, the Plan Member should submit a written treatment plan from the dentist, prior to actually having any work done. This treatment plan should itemize the services, costs, and expected dates of treatment, and explain the dentist's diagnosis. When this is received by the Plan Administrator, benefits will be estimated and you will receive an explanation of the Plan's coverage, and any charges which would remain the Plan Member's liability, without actually incurring any expenses.

Dental Benefit Exclusions

In addition to the General Exclusions, dental benefits will not be payable for:

1. Any services or supplies which are rendered by or in government facilities;

2. Any charges which the Plan Member is not legally obligated to pay;

3. Any services performed for cosmetic reasons;

4. Services for anesthetics except when rendered by a dentist, or an employee of the dentist, when received in the dentist office in conjunction with covered services;

5. Any charges for services not specifically listed as eligible expenses (including hospital and prescription drug charges);

6. Services performed by other than a licensed dentist, his/her employees or agents, or a physician acting within the scope of his/her license;

7. Dental care provided by a Health Maintenance Organization (HMO) or similar group;

8. Dental care which does not meet accepted standards of dental care adopted by the American Dental Association;

9. Any charges in excess of the Reasonable and Customary Charge for the least costly alternative consistent with adequate dental care, when such alternative services or materials are customarily provided;

10. Any charges for missed appointments or completion of claim forms;

11. Expenses related to services and supplies of the type normally associated with sport or home use;

12. Charges for the replacement of any denture or appliance lost, misplaced, or stolen;

13. Any duplicate expenses incurred prior to the end of any specified time period, or intervals between treatment;

14. Any intentionally self-inflicted illness or injury, unless the illness or injury is the result of a medical condition.

Extension of Dental Benefits

Eligible expenses incurred after the date coverage terminates will be paid only under the following circumstances:

1. Dentures or Bridges: If before coverage ceased a final impression of a denture has been prepared, charges for construction and insertion of such denture or bridge will be considered (up to the maximum benefit amount) as long as the procedures are performed within 31 days of the termination date of coverage.

2. Other Dental Procedures: If before termination a particular multiple appointment dental procedure had commenced, charges for such procedures will be considered eligible if they were performed within 31 days of the termination date of coverage and the maximum benefit amount is not exceeded.

Dental Pre-Existing Conditions Limitation

The Plan will not cover any expenses incurred prior to the effective date of coverage, or any expenses incurred after the effective date of coverage, for any work in progress or treatment prescribed which commenced prior to the effective date of coverage.

LIFE AND DISABILITY BENEFITS

Life Insurance Schedule of Benefits

Eligible Employees (including retirees) shall receive life and accidental death & dismemberment benefits in the amount specified in the following Schedule of Benefits. Coverage is provided for Employees only. Dependents are not covered for this benefit. Specific provisions related to the terms and conditions of the life and accidental death & dismemberment benefits provided by the Plan are contained in a separate booklet.

	Benefit Amount
Life Insurance	$15,000
Accidental Death and Dismemberment	$15,000

Schedule of Accident and Sickness Benefits

Non-bargaining unit employees and COBRA participants are not eligible for this benefit. If a bargaining unit Employee should become Totally Disabled due to a non-occupational illness or injury and is under the continuing care of a physician, this benefit will be payable according to the following Schedule of Benefits to help supplement his/her income during the loss of working time.

Benefits Begin:	
For Injury	1st day of disability
For Illness	8th consecutive day of disability
Benefit Amount:	
Weekly Benefit	$350
Daily Benefit	1/7 of the weekly allowance
Benefit Maximum	26 weeks

Description of Accident and Sickness Benefits

If disability is the result of illness, benefits will become payable on the 8th consecutive day that the employee is continuously disabled; if disability is due to an injury, benefit payment begins on the first day the employee is Totally Disabled due to injuries sustained in the accident. However, if a disability commences while an employee is participating in the Plan under COBRA, and the disability continues after the employee re-qualifies for coverage based on hours worked prior to the commencement of disability, then disability benefits begin on the effective date of such re-qualification. Benefits continue to a maximum of 26 weeks, or until the employee is no longer Totally Disabled whichever occurs first.

Accident and Sickness Benefits will be offset by any other disability benefits payable by any other third-party up to the $350 weekly benefit maximum. This means that if other disability coverage is payable, that coverage is primary and this Plan's disability benefit will only be payable if the other third-party coverage is less than the Plan's $350 disability benefit and the Plan's disability benefit will only pay the difference between the third-party benefit and the Plan's $350 benefit maximum. If the third-party coverage provides a weekly benefit in excess of $350, this Plan will pay no disability benefit.

Successive Periods of Disability

Two or more successive periods of disability will be considered one period of disability unless they are separated by the employee's return to work for a period of time not less than one (1) month.

Second Opinion Option

At any time subsequent to a bargaining unit Employee having received disability benefits for a period of at least 4 consecutive weeks, the Plan Administrator will have the right to require that the employee undergo a medical examination by a physician chosen by the Plan Administrator, at no expense to the employee, to determine the existence of total and continuous disability. The judgment and report of this physician will govern benefit determination.

Accident and Sickness Benefit Exclusions

In addition to the General Exclusions, Accident and Sickness Benefits are not payable for:

1. Being in or on, descending from, or falling with or from any aircraft which is in flight or motion unless the insured is a fare-paying passenger on a commercial airline flying a regularly scheduled route between definitely established airports;

2. Any disability when unemployment compensation benefits are payable unless the unemployment compensation payments terminate because of the disability.

Physical Exams

The Plan will have the right and opportunity to require a physical examination of any Plan Member at the Plan's expense as often as reasonably required during the pendency of a claim for an illness.

GENERAL PROVISIONS

General Exclusions

These general exclusions are applicable to all coverage provided by this Plan:

1. Charges or losses which are: (a) covered under any workers' compensation law or similar law; or (b) for which coverage was required to have been provided under this law even if it was not actually provided; or (c) for which coverage could have been elected under this law even if it was not actually elected by the person who could have done so (even if that person was not the covered person); or (d) otherwise arose out of or in the course of any occupation, employment or activity for wage or profit.

   However, the Fund, at its discretion, may consider advancing payment for medical and disability expenses payable in whole or in part under an applicable workers' compensation statute provided there has been a denial of primary liability by the workers' compensation carrier and you (and others as necessary) sign an acknowledgment of the Fund's first priority right of subrogation and reimbursement which assures the Fund that it will be able to recover its advance under applicable law.

2. Any illness resulting from war or any act of war, declared or undeclared, or services in the armed forces of any country.

3. Treatment while confined in a state, federal or Veterans Administration Hospital for which charges are not imposed.

4. Health services performed before the effective date or after the termination of coverage under this Plan.

5. Charges for any injury or condition that results from an accident occurring on any property where Lessee or Lessor or Owner of said property is responsible for Injury or illness or which is otherwise covered under Homeowner's insurance or premises liability. The Fund may pay the loss, expense or charge only if (a) the insurer has denied liability for the Injury or Illness or no insurance or other form of compensation is available to the Participant; (b) any medical payments coverage from the policy of insurance has been exhausted; and (c) the Participant and his or her attorney timely sign an acknowledgement of the Fund's first priority right to subrogation and reimbursement.

6. Any charges of a physician or health professional for services he or she renders to herself or himself or to any close relative. Close relative means spouse, brother, sister, parent, grandparent, or child and includes the spouse's brothers, sisters, or parents.

7. Any loss, expense or charge resulting from a Participant's participation in a riot, or in the commission of any act that may be charged as a felony, a gross misdemeanor, a Class A misdemeanor, or a Class A forfeiture, regardless of whether the Participant is charged with a felony, a gross misdemeanor, a Class A misdemeanor, or a Class A forfeiture. This exclusion does not apply to injury or illness arising out of acts of domestic violence or a medical condition.

8. Any loss, expense or charge arising from the maintenance or use of an automobile where (a) the eligible person fails to maintain the statutory minimum level of no-fault automobile medical insurance protection in the jurisdiction in which they reside (this exclusion will apply only up to the amount of no-fault automobile insurance so required); (b) the eligible person fails to apply for

any available no-fault automobile insurance; or (c) the no-fault insurer has determined that charges are not Medically Necessary, Reasonable or Customary.

9. Any loss, expense or charge arising from the maintenance or use of an automobile in non-no fault states where (a) the eligible person fails to maintain the statutory minimum level of applicable automobile medical and/or disability insurance protection in the jurisdiction in which they reside (this exclusion will apply only up to the amount of automobile medical and/or disability insurance so required); (b) the eligible person fails to apply for any available automobile medical and/or disability insurance; (c) the automobile insurer has determined that charges are not Medically Necessary, Reasonable or Customary; (d) the eligible person does not first exhaust any medical payment and/or disability coverage on the vehicle(s) involved in the accident; or (e) the eligible person and his or her attorney did not timely submit the required acknowledgment of the Plan's first priority right of subrogation and reimbursement to the Plan.

10. Any loss, expense or charge for which a third party may be liable and for which the eligible person and his or her attorney did not submit the required acknowledgment of the Plan's first priority right of subrogation and reimbursement to the Fund. The term "third party" means any individual, insurer, entity, or federal, state or local government agency, which is or may be in any way legally obligated to reimburse, compensate, or pay for an eligible person's loss, damages, injuries, or claims relating in any way to the injury, occurrence, condition, or circumstance giving rise to the fund's provision of medical, dental, or disability benefits, including but not limited to, insurers providing liability, medical expense, wage loss, uninsured motorist or underinsured motorist coverages.

11. Any loss, expense or charge arising out of or relating to an injury, occurrence, condition, or circumstance for which either (a) recovery subject to the Plan's right of subrogation or reimbursement rights has been received, (b) the Plan deems it likely that recovery will be received, or (c) a claim for such loss, expense or charge has not been submitted prior to resolution of the third party claim.

    At the discretion of the Trustees, losses, expenses or charges excluded by this section may be paid subject to the Fund's rights of subrogation and reimbursement. The amount of the loss, expense or charge excluded by this section will be the total of amounts that the Plan would otherwise pay (not the amount charged by the provider or claimed by the eligible person) up to the full amount of the recovery. This exclusion applies notwithstanding any allocation or apportionment that purports to characterize any recovery or part of a recovery as in any way not subject to the rights of subrogation or reimbursement, including but not limited to, any apportionment to a spouse for loss of consortium.

12. Any loss, expense or charge incurred by an eligible person at a time that the eligible person owes payment to the Fund because of overpayments of benefits and benefit payments made in reliance upon incorrect, misleading or fraudulent statements or representations by such person, or where such person or other persons covered because of his or her relationship to the participant has failed to honor the Plan's rights of subrogation or reimbursement or otherwise failed to cooperate with the Plan. The Plan has the right to deny future benefit benefits payments for charges excluded under this paragraph, suspend and/or terminate coverage under the Plan.

PROCEDURES FOR REIMBURSEMENT OF MEDICAL BENEFIT SERVICES

Proof of loss. Claims for services must be submitted to the Plan Manager at the address shown below. You must submit an itemized bill, which documents the date and type of service, provider name and charges, for the services incurred. Claims for services must be submitted within 90 days after the date services were first received for the injury or illness upon which the claim is based. Failure to file a claim within this period of time shall not invalidate nor reduce any claim if it was not reasonably possible to file the claim within that time. However, such claim must be filed as soon as reasonably possible and in no event, except in the absence of your legal capacity, later than 15 months from the date services were first received for the injury or illness upon which the claim is based. If the Plan is discontinued or if HPAI ceases to act as the Plan Manager, the deadline for claim submission is 180 days. The Plan Manager may request that additional information be submitted, as needed, to make a claim determination.

Send itemized bills to:
Claims Department
HealthPartners
P.O. Box 1289
Minneapolis, MN 55440-1289

Time of payment of claims. Benefits will be paid under the Plan within a reasonable time period.

Payment of claims. Payment will be made according to the Plan Sponsor's coverage guidelines. All or any portion of any benefits for non-network services provided under the Plan on account of hospital, nursing, medical, or surgical services may, at the Plan Manager's option and, unless you request otherwise in writing not later than the time of filing the claim, be paid directly to the Non-Network Provider rendering the services. Payment for Covered Services may be offset to recover overpayments made to Network Providers.

Clerical error. If a clerical error or other mistake occurs, that error does not deprive you of coverage for which you are otherwise eligible nor does it give you coverage under the Plan for which you are not eligible. These errors include, but are not limited to, providing misinformation on eligibility or benefit coverage. Determination of your coverage will be made at the time the claim is reviewed. It is your responsibility to confirm the accuracy of statements made by the Plan Sponsor or the Plan Manager, in accordance with the terms of this SPD and other Plan documents.

HRA Claims – See the HRA Plan for Claim Filing Details.

DENTAL AND PRESCRIPTION DRUG CLAIMS

Dental Claims – For in-network Dental Benefit Claims, your claims are submitted to the Plan by the provider. For out-of-network dental claims, you will be required to pay the provider directly and then submit your receipts to the Plan Administrator – Wilson-McShane Corporation, to receive reimbursement.

Prescription Drug Claims – All prescription drug claims are submitted by your network pharmacy and will be processed through the Plan's Pharmacy Benefit Provider ProAct.

TIME OF NOTIFICATION TO CLAIMANT OF CLAIMS

An initial determination of a claim for medical benefits must be made by Plan Manager within 30 days. This time period may be extended for an additional 15 days, provided that the Plan Manager determines that such an extension is necessary due to matters beyond the control of the Plan. If such extension is necessary, you will be notified prior to the expiration of the initial 30-day period.

You will receive written notification of any initial adverse claim determination as provided by applicable law.

MEDICAL CLAIM DENIALS AND CLAIM APPEALS PROCESS

If your claim for benefits under the Plan is wholly or partially denied, you are entitled to appeal that decision. Your Plan provides for two levels of appeal to the named fiduciary of your Plan or its delegate for purposes of Medical Benefits claims. You may also have the right to an external review as described further below. You must exhaust the first and second levels of the appeal process prior to bringing a civil action under section 502(a) of ERISA. The steps in this appeal process are outlined below.

Medical Benefits - First level of appeal to the Plan Manager. You or your authorized representative must file your appeal for medical benefits within 180 days of the adverse decision received from the Plan Manager. Send your written request for review, including comments, documents, records and other information relating to the claim, the reasons you believe you are entitled to benefits, and any supporting documents to:

Member Services Department
HealthPartners
8170 33rd Avenue South, P.O. Box 1309
Minneapolis, MN 55440-1309

Upon request and at no charge to you, you will be given reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

The Plan Manager will review your appeal and will notify you of its decision within 30 days.

The time period may be extended if you agree.

Medical Benefits - Concurrent care appeal. If you are appealing a reduction or termination of an ongoing course of treatment that has been previously approved by HealthPartners, you will have continued coverage under the Plan, pending the outcome of the appeal. This does not apply to requests for an extension to the already approved period of treatment or number of visits.

All notifications described above will comply with applicable law.

Dental and Prescription Drug Benefit Appeals. For all other forms of medical benefits such as Dental or Prescription Drug Benefits, see the Claim Appeal Procedure below if your claim for such benefits has been denied and you wish to appeal.

CLAIM APPEAL PROCEDURE

If all or part of your first level medical claim appeal is denied by the Plan Manager or your dental or prescription drug claim has been denied, you have the right to appeal those decisions and request a review of the claim. The procedures for appealing a claim decision are:

1. Compose a claim appeal which explains why you believe your claim should be reviewed.

2. Attach any additional information you think will help a favorable decision to be made on your claim.

3. Return your completed appeal, along with any additional information you are submitting, to the

Plan Administrator:

Heat and Frost Insulators Local 34 Administration Office
3001 Metro Drive, Suite 500
Bloomington, MN 55425

Your claim appeal must be filed in writing at the Plan Administrator's office within 180 days of the date the claim denial was mailed to you.

When appealing a claim, you have certain rights under federal law. These include:

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

2. You will be provided upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

3. The review by the Plan will take into account all comments, documents, records, and other information submitted by you related to your claim, whether or not the information was submitted or considered in the initial benefit determination.

4. If your appeal is for disability benefits, the Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim and further, will provide you with such rational as soon as possible and sufficiently in advance of the date of review of the denial by the Plan so as to give you a reasonable opportunity to respond prior to that date.

Another person may act on your behalf in pursuing a benefit claim or claim appeal, but only after you have signed and delivered a letter to the Plan Administrator at the Fund Office specifically naming the person as your authorized representative. In any event, neither you nor any person you name as your representative will have the right to make a personal appearance before the Board of Trustees or before any committee created by the Board of Trustees.

Time Frames for Deciding Claim Appeals

The Board of Trustees will review your appeal at its next regularly scheduled meeting; however, if your appeal was received by the Plan within 30 days of the Board of Trustees meeting, your appeal will be reviewed at the Board's second regularly scheduled meeting following the Plan's receipt of your claim appeal. If special circumstances require, such as the need to hold a hearing, the review of your appeal may be delayed until the Board's third meeting following your request for an appeal. If this extension is required, the Plan will notify you of the extension and of the special circumstances requiring the extension.

After a decision is made concerning your appeal, you will be notified of the decision by the Plan within 5 days of the decision being made. The written notification of your denial will state:

1. The specific reason(s) for the determination.

2. Reference to the specific Fund provision(s) on which the determination is based.

3. A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge.

4. A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

If an internal rule, guideline, or protocol was relied upon by the Fund, you will receive either a copy of the rule or a statement that it is available upon request at no charge. If the determination was based on Medical Necessity, or because the treatment was Experimental or Investigative, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Fund to your claim, or a statement that it is available upon request at no charge.

If the decision involved disability benefits, you will receive a written explanation providing for the basis for disagreeing with or not following (1) the views presented by your health care and vocational professionals; (2) the views of medical and/or vocational experts whose advice was obtained by the Plan in connection with this adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination; and (3) your disability determination from the Social Security Administration.

External Third-Party Review of an Adverse Appeal Decision

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

Standard External Review for 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.

1. Within five (5) business days following the date of receipt of the external review request, the Plan Administrator will complete a preliminary review of the request to determine whether:

    a. 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;

    b. The adverse benefit determination or the final adverse benefit determination is not based on the fact that you were not eligible under the Plan;

    c. You have exhausted the Plan's internal appeal process (unless exhaustion is not required); and

    d. You have provided all the information and forms required to process an external review.

2. Within 1 business day after completion of the preliminary review, the Plan 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 4-month period you had to file a request for an external review or 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.

3. If the request is complete and eligible for external review, the Plan Administrator will assign an accredited independent review organization (IRO) to conduct the external review.

    a. 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 10 business days that the IRO must consider when conducting the external review.

    b. The Plan Administrator will provide documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO.

    c. The IRO will review all of the information and documents timely received and is not bound by the Plan Administrator's prior determination. The IRO may consider the following in reaching a decision:

        1) Your medical records;

        2) The attending health care professional's recommendation;

        3) Reports from appropriate health care professionals and other documents submitted by the Plan Administrator, you, or your treating provider;

        4) Evidence-based practice guidelines;

        5) Any applicable clinical review criteria developed and used by the Plan Administrator; and

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

    d. The IRO will provide written notice of the final external review decision within 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

1. You may request an expedited external review when you receive:

    a. 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

    b. 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.

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

3. When the Plan Administrator determines that your request is eligible for external review an IRO will be assigned. The Plan 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.

4. The IRO must consider the information or documents provided and is not bound by the Plan 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 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 48 hours to the claimant and the Plan.

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 HealthPartners Network.

"Out-of-network" describes providers and facilities that haven't signed a provider agreement with HealthPartners. 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 HealthPartners 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.

PAYMENTS TO THOSE ELIGIBLE FOR MEDICAL ASSISTANCE

Payment of benefits under the Plan with respect to any Plan participant will be made in accordance with any assignment of rights made by or on behalf of such participant or a beneficiary of the participant as required by any applicable state plan for medical assistance which is approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act. In enrolling an individual as a participant or beneficiary or in determining or making any payment of benefits for or on behalf of an individual as a participant or beneficiary in the Plan, the Plan will not take into account the fact that such individual is eligible for or is provided medical assistance under an applicable state plan for medical assistance which has been approved under Title XIX of the Social Security Act. In any case in which the Plan has a legal liability to make payments of benefits for or on behalf of a participant or beneficiary for items or services as to which payment has legally been made under any applicable state plan for medical assistance approved under Title XIX of the Social Security Act, such payment by the Plan will be made in accordance with any applicable state law which provides that the state has acquired a right to payment for such items or services with respect to the participant or beneficiary.

COORDINATION OF BENEFITS

You agree, as a Covered Person, to permit the Plan Manager to coordinate payments under any other medical benefit plans as specified below, which cover you or your dependents. You also agree to provide any information or submit any claims to other medical benefit plans necessary for this purpose. If you fail to provide this information, your claim may be delayed or denied. You agree to authorize the Plan Manager's billing to other medical plans, for purposes of coordination of benefits.

Unless applicable law prevents disclosure of the information without the consent of the patient or the patient's representative, each person claiming benefits under the Plan must provide any facts needed to pay the claim.

For purposes of Coordination of Benefits, all medical coverage under a non-Medicare plan will always pay before the HRA portion of this Plan.

1. Applicability.

a. This Coordination of Benefits (COB) provision applies to the Plan when a Covered Employee or the Covered Employee's Covered Dependent has medical care coverage under more than one plan. “Plan” and “The Plan” are defined below.

b. If this Coordination of Benefits provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of The Plan are determined before or after those of another plan. The benefits of The Plan:

(1) shall not be reduced when, under the order of benefit determination rules, benefits under The Plan are determined before another plan; but

(2) may be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in paragraph 4. below.

2. Definitions.

a. **“Plan”** is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

(1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

(2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

b. **“The Plan”** is the part of the Plan that provides benefits for medical care expenses.

c. **"Primary Plan/Secondary Plan"** The order of benefit determination rules state whether The Plan is a Primary Plan or Secondary Plan as to another plan covering the person. When The Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When The Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering the person, The Plan may be a Primary Plan as to one or more of the plans and may be a Secondary Plan as to a different plan or plans.

d. **"Allowable Expense"** is a necessary, reasonable and customary item of expense for medical care when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

When benefits are reduced under a primary plan because a Covered Person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions and preferred provider arrangements.

e. **"Claim Determination Period"** is a plan year. However, it does not include any part of a year during which a person has no coverage under The Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

3. Order of Benefit Determination Rules.

a. **General**. When there is a basis for a claim under The Plan and another plan, The Plan is a Secondary Plan which has its benefits determined after those of another plan, unless:

(1) the other plan has rules coordinating its benefits with those of The Plan; and

(2) both those rules and The Plan's rules, in subparagraph b. below, require that The Plan's benefits be determined before those of the other plan.

b. **Rules**. The order of benefits are determined using the first of the following rules which applies:

(1) Nondependent/Dependent. The benefits of the plan which cover the person as a Covered Person or subscriber (that is, other than as a dependent) are determined before those of the plan which cover the person as a dependent.

(2) Dependent Child/Parents not Separated or Divorced. Except as stated in subparagraph b. (3) below, when The Plan and another plan cover the same child as a dependent of different persons, called "parents":

(a) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

(b) if both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time. However, if the other plan does not have the rule described in (a) immediately above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

(3) Dependent Child/Separated or Divorced. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(a) first, the plan of the parent with custody of the child;

(b) then, the plan of the spouse of the parent with the custody of the child; and

(c) finally, the plan of the parent not having custody of the child. However, if the specific terms of a court decree state that one of the parents is responsible for the medical care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(4) Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for medical care expenses of the child, the plans covering the child follow the order of benefit determination rules outlined in subparagraph b. (2).

(5) Active/Inactive Enrollee. The benefits of a plan which covers a person as a Covered Employee who is neither laid off nor retired (or as that Covered Employee's dependent) are determined before those of a plan which cover that person as a laid off or retired Covered Employee (or as that Covered Employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(6) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered a Covered Person or subscriber longer are determined before those of the plan which covered that person for the shorter term.

4. Effect on the benefits of this Plan.

a. **When this section applies**. This paragraph 4. applies when, in accordance with paragraph 3. "Order of Benefit Determination Rules," The Plan is a Secondary Plan as to one or more other plans. In that event the benefits of The Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in b. immediately below.

b. **Reduction in the Plan's benefits**. The benefits of The Plan will be reduced when the sum of:

(1) the benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and

(2) the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of The Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses. When the benefits of The Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of The Plan.

c. **Benefit reserve**. The Secondary Plan shall calculate its savings by subtracting the amount that it paid as a Secondary Plan from the amount it would have paid had it been primary "COB Savings." These COB Savings shall be recorded in the benefit reserve for the Covered Person and shall be used by the Secondary Plan to pay any allowable expenses, not otherwise paid, that are incurred by the Covered Person during the Claim Determination Period. As each claim is submitted, the Secondary Plan must:

(1) determine its obligation, pursuant to the contract;

(2) determine whether a benefit reserve has been recorded for the Covered Person; and

(3) determine whether there are any unpaid allowable expenses during that Claim Determination Period.

If there is a benefit reserve, the Secondary Plan shall use the Covered Person's recorded benefit reserve to pay up to 100% of the total allowable expenses incurred during the Claim Determination Period. At the end of the Claim Determination Period, the benefit reserve returns to zero. A new benefit reserve must be created for each Claim Determination Period. (A Claim Determination Period is based on plan year.)

5. Right to receive and release needed information. Certain facts are needed to apply these COB rules. The Plan Manager has the right to decide which facts are needed. Consistent with applicable state and federal law, the Plan Manager may get needed facts from or give them to any other organization or person, without your further approval or consent. Unless applicable federal or state law prevents disclosure of the information without the consent of the patient or the patient's representative, each person claiming benefits under The Plan must give any facts the Plan Manager needs to pay the claim.

6. Facility of payment. A payment made under another plan may include an amount which should have been paid under The Plan. If it does, the Plan Sponsor may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under The Plan. The Plan Sponsor will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

7. **Right of recovery**. If the amount of the payments made by the Plan Sponsor is more than the amount that should have paid under this COB provision, the Plan Manager may recover the excess from one or more of:

   a. the persons it has paid or for whom it has paid;
   b. insurance companies; or
   c. other organizations.

   The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

   The benefits provided by the Plan do not apply to injury or disease covered by no-fault insurance, employers liability laws (including workers' compensation), and care available or required to be furnished by or through national or state governments or their agencies including care to which a Covered Person is legally entitled and for which facilities are reasonably available for military service-connected conditions or disabilities. Subject to the Plan's rights in "Rights of Reimbursement and Subrogation" above, medically necessary services will be provided upon request and only expenses incurred for medical treatment otherwise covered by the Plan will be paid if the no-fault insurer, employer, or national or state government or its agencies refuse to pay said expenses. You must cooperate with the Plan Manager's program to bill allowable no-fault and workers' compensation claims to the appropriate insurer(s).

Coordination of Benefits with Other Types of Insurance

This Plan is not in lieu of and does not affect the requirement for coverage under any plan of no-fault automobile insurance or other automotive insurance which provides medical coverage. That type of insurance is deemed to be primary for any claims arising out of the maintenance or use of an automobile. The Plan may require you to arbitrate any discontinuance or non-payment of no-fault benefits before a claim will be considered under this Plan. Coverage under this Plan is deemed to be secondary coverage to any plan or policy of insurance which may pay medical expenses for a specific risk, including but not limited to, for example, any automobile policy, homeowners policy or premises insurance policy. The Plan may require that you show that you have made a reasonable effort to find out if there is an applicable other insurance policy. Benefits that might otherwise be payable under another insurance policy will not be paid by the Plan merely because you have not made a claim under the other insurance policy.

Coordination with Third Party Liability Coverage

If you and/or your dependents are entitled to be paid for any loss from any third party and/or liability, casualty programs, self-insurance or insurance programs providing coverage to such third parties, then this Plan shall only be secondarily liable for any health care benefits provided herein and such third party or third party coverage shall be primarily liable. In the event you and/or your dependents suffer loss for which a third party may be liable, you and/or your dependents must first file a claim for benefits with such third party, its agent, carrier, or other liability, self-insurance or casualty program.

Right to Recover Payments

If payments have been made which were not required according to the terms of the Plan, the Plan will have the right to recover such payments from any of the following: any persons to, of, for, or with respect to whom the payments were made; any insurance companies; or any other organizations or persons.

MEDICARE AND THE PLAN

The provisions in this section apply to some, but not all, Covered Persons who are eligible for Medicare. They apply in situations where the federal Medicare Secondary Payer Program allows Medicare to be the primary payer of a Covered Person's medical care claims. Consult your Employer to determine whether or not Medicare is primary in your situation.

In general, Medicare is secondary payer for Medicare enrollees who: (1) are active employees and (2) are covered by Medicare because they have reached age 65 when there are 20 or more employees in the group. The Medicare secondary payer rules change from time to time and the most recent rule will be applied.

Medicare is the primary payer:

- For Covered Persons with end stage renal disease, after the 30-month period following the earlier of (1) the month in which the Covered Person begins a regular course of renal dialysis, or (2) the first of the month in which the Covered Person became entitled to Medicare, if the Covered Person received a kidney transplant without first beginning dialysis. This is regardless of the size of the Employer.
- For retirees who are age 65 or over.
- For Covered Persons under age 65, who are covered by Medicare because of disability (other than end stage renal disease), when (1) the Employer employs fewer than 100 employees and the Covered Person or their spouse or parent has group health plan coverage due to current employment, or (2) the Covered Person or their spouse or parent has coverage not due to current employment, regardless of the number of employees of the Employer.

If Medicare is the primary payer, the benefits under the Plan are not intended to duplicate any benefits to which Covered Persons are, or would be, entitled under Medicare. All sums payable under Medicare for services provided pursuant to the Plan shall be payable to and retained by the Plan Sponsor. Each Covered Person shall complete and submit to the Plan such consents, releases, assignments and other documents as may be requested by the Plan Manager in order to obtain or assure reimbursement under Medicare for which Covered Persons are eligible.

If Medicare is the primary payer, the Plan also reserves the right to reduce benefits for any medical expenses covered under the Plan by the amount of any benefits available for such expenses under Medicare. This will be done before the benefits under the Plan are calculated. Charges for services used to satisfy a Covered Person's Medicare Part B deductible will be applied under the Plan in the order received by the Plan. Two or more charges for services received at the same time will be applied starting with the largest first.

If Medicare is the primary payer, the benefits under the Plan will only be reduced to the extent that the Covered Person has actually enrolled in Medicare.

The provisions of this section will apply to the maximum extent permitted by federal or state law. The Plan will not reduce the benefits due any Covered Person due to that Covered Person's eligibility for Medicare where federal law requires that the Plan determine the benefits for that Covered Person without regard to the benefits available under Medicare.

Enrolling in Medicare

It is important that you or your spouse visit an office of the Social Security Administration during the three-month period prior to your 65th birthday to learn all about Medicare.

It is very important that when you or your eligible dependent spouse become eligible for Medicare, you enroll for Part A and B immediately. If you are eligible for Medicare, payment by this Plan will be reduced by any amounts payable by Medicare. This rule will hold true regardless of whether you or your dependent spouse have enrolled in Medicare.

For questions on coverage by this Plan or help in comparing benefits offered by this Plan and Medicare, please contact the Fund Office.

Subrogation and Reimbursement

Introduction

The Plan has a first priority subrogation and reimbursement right if it provides benefits resulting from or related to an injury, occurrence or condition for which the 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

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.

STATEMENT OF RIGHTS OF PLAN PARTICIPANTS

As a participant in the Heat and Frost Insulators Local 34 Health and Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) as amended. ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as the result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan in the rules governing your COBRA continuation coverage rights.

Reduction or elimination of 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, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon 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 the 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 a plan document or the latest annual report 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 to pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in Federal Court. In addition, if you disagree with the Plan's decision or lack thereof concerning a qualified medical child support order, you may file suit in Federal Court. If it should happen that Plan 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 a suit in 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 those costs and fees. If you lose, the court may order you to pay those 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 obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

IMPORTANT INFORMATION ABOUT THE PLAN

Name and Type of Plan
The Plan name is "Heat and Frost Insulators Local 34 Health & Welfare Plan."

Board of Trustees
A Board of Trustees is responsible for the operation of this Plan. The Board of Trustees consists of an equal number of Employer and Union representatives selected by the Employers and the Local Union which have entered into collective bargaining agreements which relate to this Plan. If you wish to contact the Board of Trustees, you may use the address and telephone number below.

Board of Trustees
Heat and Frost Insulators Local 34 Health & Welfare Plan
P.O. Box 220
Minneapolis, MN 55440-0220
(952) 544-8332

As of April 1, 2022, the Trustees of this Plan are:

UNION TRUSTEES:	EMPLOYER TRUSTEES:
Albert Byers III Heat & Frost Insulators Local 34 95 Empire Drive St. Paul, MN 55103	Martha Henrickson Management Guidance LLP 1270 Northland Drive Suite 150 Mendota Heights, MN 55120
Samuel Schultz Heat & Frost Insulators Local 34 95 Empire Drive St. Paul, MN 55103	Tim Hynes Thermech, Inc. 4401 Quebec Ave. No. Suite A Minneapolis, MN 55427
Lee Houske Heat & Frost Insulators Local 34 95 Empire Drive St. Paul, MN 55103	Mike Poot NYCO, Inc. 10730 Briggs Drive, Suite B Inver Grove Heights, MN 55077

Alternate:
Eric Houske
Heat & Frost Insulators Local 34 JAC
95 Empire Drive
St. Paul, MN 55103

Plan Sponsors
The Plan was established jointly by Local 34 of the International Association of Heat and Frost Insulators and Allied Workers (95 Empire Drive, St. Paul, MN 55103) and the Thermal Insulation Contractors Association (TICA) (1270 Northland Drive, Suite 150, Mendota Heights, MN 55120).

Plan Administrator
The Board of Trustees is the Plan Administrator. Trustees are appointed by the Union and Employer plan sponsors. The Board of Trustees has delegated certain administrative duties to a contract administrator, Wilson-McShane Corporation, Inc. Wilson-McShane Corporation administers the Plan on a day-to-day basis.

Identification Numbers
The plan number assigned to this Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501.

The Employer Identification Number ("EIN") assigned to the Board of Trustees by the Internal Revenue Service is 41-6263066.

Organizations Through which Benefits are Insured and/or Administered

Medical, HRA and EAP Benefits

Insured by: SELF-FUNDED from Plan assets
Administered by: HealthPartners Administrators, Inc.
P.O. Box 1309
Minneapolis, MN 55440-1309
952-883-6000

Medical benefits are paid from Plan assets but are administered by HealthPartners. The Plan utilizes the network of providers available through HealthPartners. HealthPartners is also the Plan's administrator for the Health Reimbursement Account (HRA) and the Employee Assistance Program provider.

The Plan maintains a policy of stop-loss insurance for medical benefits. This policy reimburses the Plan for any medical benefits paid on behalf of an individual in excess of a set amount each policy year.

Prescription Drug Benefits

Insured by: SELF-FUNDED from Plan assets
Administered by: ProAct
1230 Highway 11
Gouvernor, NY 13642

Life and AD&D

Insured by: Symetra Life Insurance Company

Administered by: Symetra Life Insurance Company
Bellevue, WA 98004-51355

Life Insurance and Accidental Death and Dismemberment benefits are insured by Symetra Life Insurance Company, Group Policy Number 01-020413-00. They are also administered by Symetra Life Insurance Company on behalf of the Plan.

Dental Benefits

Insured by: SELF-FUNDED from Plan assets

Administered by: Wilson-McShane Corporation, Inc.
3001 Metro Drive, Suite 500
Bloomington, MN 55425

Dental benefits are paid from Plan assets, but administered by Wilson-McShane Corporation, Inc. The Plan uses a network of dental providers available through Delta Dental of Minnesota.

Short Term Disability	Insured by:	SELF-FUNDED from Plan assets
	Administered by:	Wilson-McShane Corporation, Inc. 3001 Metro Drive, Suite 500 Bloomington, MN 55425 Short Term Disability benefits are paid from Plan assets, but administered by Wilson-McShane Corporation, Inc.

Agent for Service of Legal Process
The Board of Trustees is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal document should be served upon the Board of Trustees at the Administration Office or upon any individual Trustee.

Collective Bargaining Agreements and Participation Agreements
This Plan is maintained pursuant to collective bargaining agreements between the Employers and the Local Union for the benefit of bargaining unit employees and pursuant to Participation Agreements between Employers and the Fund for the benefit of non-bargaining unit employees.

The Administration Office will provide you, upon written request, (1) information as to whether a specific employer or employee organization is a sponsor of the plan and, if the employer or employee organization is a plan sponsor, that sponsor's address, and (2) a copy of any collective bargaining agreements requiring contributions to the Plan.

Source of Contributions
The benefits described in this booklet are provided through Employer contributions. The amount of Employer contributions and the Employees on whose behalf contributions are made are determined by the provisions of the collective bargaining agreements for bargaining unit employees and by Participation Agreements for non-bargaining unit employees.

The Trust Fund also receives contributions from retirees and employees for the purpose of paying for retiree coverage and continuation coverage. The amount of retiree premiums are calculated as indicated in the section entitled "Eligibility and Participation" in this booklet. COBRA premiums are determined according to applicable law.

Plan Year
The Plan year is April 1 to March 31.

Trust Fund
All assets are held in trust by the Board of Trustees for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses. Medical, dental, and disability benefits are paid directly from the Trust Fund and are limited to the Trust Fund assets available for paying such benefits. Life insurance and accidental death benefits are provided through insurance contracts.

Upon Plan termination, the Trustees will apply any remaining Trust Fund Assets according to the Trust Agreement. In no event will Trust Fund assets revert back to any sponsoring Employer or Union or be used for a purpose other than paying benefits to Plan participants and administrative expenses of the Plan.

Type of Plan
This Plan is a group health plan maintained for the purpose of providing life, disability and health benefits as outlined in this booklet.

Claim Procedure
The procedure to follow for filing a claim or appealing a denied claim is set forth in this booklet in the sections entitled "Submitting a Claim" and "Claim Processing and Appeal Procedures."

Eligibility and Benefits
The types of benefits provided and the Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits are described in this booklet.

Amendment and Termination
The Trustees may modify or amend the Plan, and to thereby reduce or eliminate benefits under the Plan, from time to time at their sole discretion, and the amendments or modifications which affect participants will be communicated to them. Although it is the intention that this Plan be ongoing, it may be terminated. Upon termination, the rights of the Plan Members to benefits are limited to claims incurred and due up to the date of termination. Any termination of the Plan will be communicated to participants. Under the existing schedule of benefits, certain classes of retirees are entitled to receive benefits from the Plan. These benefits are, however, provided solely at the discretion of the Plan Trustees and no existing or future retiree has a vested right to such benefits. The Trustees reserve the right to change, modify, or eliminate, at any time for any reason, the benefits provided for existing and future retirees.

The Plan Trustees and their delegates have the discretion and final authority to interpret and construe the terms of the Plan and Trust, to determine coverage and eligibility for benefits under the Plan, and to make all other determinations deemed necessary or advisable for the discharge of their duties or the administration of the Plan and Trust. The discretionary authority of the Plan Trustees and their delegates is final, absolute, conclusive and exclusive, and binds all parties so long as exercised in good faith. It is specifically intended that judicial review of any decision of the Plan Trustees or their delegates be limited to the arbitrary and capricious standard of review.

MEDICAL DATA PRIVACY

Introduction

The federal Department of Health and Human Services adopted regulations governing the Plan's use and disclosure of your health information. The regulations arose from the Health Insurance Portability and Accountability Act of 1996 (HIPAA). While the Plan has always taken care to protect the privacy of your health information, the new regulations require the Plan to adopt more formal procedures and to tell you about these procedures in this booklet. The information below discusses ways in which the Plan uses and discloses your health information.

Under HIPAA, the Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to tell you about:

1. The Plan's uses and disclosures of Protected Health Information (PHI);

2. Your privacy rights with respect to your PHI;

3. The Plan's duties with respect to your PHI;

4. Your right to file a complaint with the Plan and the Secretary of the U.S. Department of Health and Human Services; and

5. The person or office to contact for further information about the Plan's privacy practices.

A. The Plan's Use and Disclosure of PHI

The Plan will use Protected Health Information (PHI) to the extent of and according to the uses and disclosures allowed by the Medical Data Privacy Regulations (Privacy Regulations) adopted under HIPAA, including for purposes related to *Health Care Treatment, Payment, and Health Care Operations.*

The Plan will enter into agreements with other entities known as Business Associates to perform some of these functions on behalf of the Plan. Each Business Associate will be allowed to use and disclose only the minimum amount of PHI needed to perform the Business Associate's duties on behalf of the Plan. The Plan's agreements with its Business Associates will also meet the other requirements of the Privacy Regulations.

Use of PHI for Treatment Purposes

Treatment includes the activities relating to providing, coordinating or managing health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. As a health plan, the Plan is generally not involved in treatment situations but may, from time-to-time, release PHI to assist providers in your treatment.

Use of PHI for Payment and Health Care Operations

Payment includes the Plan's activities to obtain premiums, contributions, self-payment, and other payments to determine or fulfill the Plan's responsibility for coverage and providing benefits under the Plan. It also includes the Plan obtaining reimbursement or providing reimbursement for providing health care that has been provided. These activities include but are not limited to the following:

1. Determining eligibility or coverage under the Plan;

2. Adjudicating claims for benefits (including claim appeals and other benefit payment disputes);

3. Subrogation;

4. Coordination of Benefits;

5. Establishing self-payments by persons covered under the Plan;

6. Billing and collection activities;

7. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to covered persons' inquiries about payments;

8. Obtaining payment under stop-loss or similar reinsurance;

9. Reviewing whether claims are payable under the Plan, including whether they are Medically Necessary, Reasonable and Customary, or otherwise payable;

10. Reviewing coverage under the Plan, appropriateness of care, or justification of charges;

11. Utilization review, including precertification, preauthorization, concurrent review and retrospective reviews;

12. Disclosing to consumer reporting agencies certain information related to collecting contributions or reimbursement (the information that may be released is: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and

13. Reimbursement to the plan.

Health Care Operations can include any of the following activities. While the Plan does not currently use or release PHI for all of these activities, it may do so in the future to perform health care operations of the Plan:

1. Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines as long as general knowledge is not the primary purpose of these studies; population based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;

2. Reviewing the competency or qualifications of health care professionals; evaluating provider performance; accreditation, certification, licensing or credentialing activities;

3. Underwriting, premium rating and other activities relating to creating, renewing or replacing a health insurance contract (or reinsurance) or health benefits under the Plan;

4. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

5. Planning and development, such as conducting cost-management and planning related analyses relating to managing and operating the Plan (including formulary development and administration, development or improvement of methods of payment or coverage policies); and

6. Management and general administrative activities of the Plan, including but not limited to:

    a. Managing activities related to implementing and complying with the Privacy Regulations;

    b. Resolving claim appeals and other internal grievances;

    c. Merging or consolidating the Plan with another Plan, including related due diligence; and

    d. As permitted under the Privacy Regulations, creating de-identified health information or a limited data set.

B. Other Uses and Disclosures of PHI

The Privacy Regulations permit certain other uses and disclosures of your PHI. These include, for example, releasing PHI to personal representatives of deceased covered persons, releasing PHI for public health activities, releasing PHI for court proceedings, and releasing PHI for law enforcement and similar purposes. If the Plan releases PHI in any of these other permitted situations, it will do so according to the requirements of the Privacy Regulations.

The Privacy Regulations also permit the Plan to release PHI if it receives a valid authorization from you. If the Plan receives a valid authorization, the Plan will disclose PHI to the person or organization you authorize to receive the information. This may include, for example, releasing information to your spouse, to the pension plan, other retirement plans, vacation plan or similar plan for the purposes related to administering those plans.

C. Release of PHI to the Board of Trustees

The Plan will disclose PHI to the Board of Trustees, which is considered the Plan Sponsor under the Privacy Regulations. The Plan has received a certificate from the Board of Trustees that the plan documents, including this Summary Plan Description, have been amended to incorporate the following provisions.

The Board of Trustees will receive and use PHI only for the Plan administration functions that the Trustees perform for the Plan. In addition, the Trustees will:

1. Not use or further disclose PHI other than as permitted or required by the Summary Plan Description or as required by law.

2. Ensure that any agents, including subcontractors, to whom the Board of Trustees provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Board of Trustees with respect to such PHI;

3. Not use or disclose PHI for employment-related actions and decisions unless authorized by the person who is the subject of the PHI;

4. Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the person who is the subject of the information;

5. Report to the Plan any PHI use or disclosure that is inconsistent with the allowed uses or disclosures of which it becomes aware;

6. Make PHI available to a person who is the subject of the information according to the Privacy Regulations' requirements;

7. Make PHI available for amendment and incorporate any amendments to PHI according to the requirements of the Privacy Regulations;

8. Make available the PHI required to provide an accounting of disclosures;

9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for the purposes of determining the Plan's compliance with the Privacy Regulations; and

10. If feasible, return or destroy all PHI received from the Plan that the Trustees maintain in any form, and retain no copies of the PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

D. Trustee Access to PHI for Plan Administration Functions

As required under the Privacy Regulations, the Plan will give access to PHI to the Board of Trustees, and the Trustees will be able to use PHI, for purposes of hearing and determining claim appeals; making other determinations concerning claims payments; assisting covered persons with eligibility and benefit issues; Plan benefit design; amending, modifying and terminating the Plan; and Plan management issues.

E. Noncompliance Issues

If the persons described above do not comply with this Summary Plan Description, the Board of Trustees will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

F. Plan's Privacy Officer and Contact Person

As required by the Privacy Regulations, the Plan has named a Privacy Officer to oversee the Plan's compliance with the Privacy Regulations. The Plan has also named a Contact Person to help answer your questions concerning the Privacy Regulations and your PHI. You can also call the Contact Person if you have any complaints concerning the use or disclosure of your PHI. If you have any questions or complaints concerning your PHI, please contact the Plan Administrator and ask to speak with the Plan's Contact Person.

HIPAA SECURITY

Introduction

The Department of Health and Human Services adopted regulations governing the Plan's obligation to maintain the security of your health information. The regulations arose from the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). These regulations work in conjunction with the Medical Data Privacy Regulations ("Privacy Regulations"), which provisions are outlined in a previous amendment to the Plan, effective April 14, 2004. While the Plan has always taken care to secure your health information, the new regulations require the Plan, along with the Fund Administrator, to take some additional steps, in addition to those required by the Privacy Regulations, to maintain the electronic, physical and technical security of your protected health information. The information below outlines the additional steps the Plan has taken to secure your health information in compliance with the HIPAA Security Regulations.

A. Policies to Protect PHI in Electronic Form

The Plan, in conjunction with the Fund Administrator, has implemented administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic protected health information (ePHI) (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these regulations) that they create, receive, maintain or transmit on behalf of the Fund. The Trustees will report to the Plan any security incident of which they become aware.

B. Business Associates

The Plan will enter into agreements with other entities known as "Business Associates" to perform functions as part of the administration of the Plan. The Plan's agreements with its Business Associates will require that the electronic, physical and technical security of your ePHI be maintained.

C. Access to ePHI for Plan Administrative Functions

As indicated in the section of the Summary Plan Description covering the Privacy Regulations, the Plan will give access to ePHI to the Board of Trustees, agents of the Trustees and Business Agents of the union. Any such disclosures of your ePHI to the above noted personnel are supported by reasonable and appropriate security measures. If any of the above noted personnel fail to comply with these provisions, the Board of Trustees will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions as appropriate.

D. If You Have Any Questions

The Fund Administrator is largely responsible for maintaining the security of your ePHI. The Fund Administrator has appointed a Security Officer for purposes of Security Regulations compliance. If you have questions regarding the security of your ePHI, you may contact the Security Officer through the Fund Administrator.